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The Social Construction of the Feebleminded Threat: Implementation of the Sexual Sterilization Act in Alberta, 1929-1972

by

Jana Marie Grekul ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial
fulfillment of the requirements for the degree of *Doctor of Philosophy*

Department of Sociology

Edmonton, Alberta
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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *The Social Construction of the Feebleminded Threat: Implementation of the Sexual Sterilization Act in Alberta, 1929-1972* submitted by *Jana Grekul* in partial fulfillment of the requirements for the degree of *Doctor of Philosophy*.

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Abstract

In the early 1900s, eugenics doctrine was sweeping the western world. Alberta, Canada was no exception. The province is exceptional in that it started its eugenics program at the same time as other jurisdictions but continued it for much longer. In 1928 the *Sexual Sterilization Act* was passed and by 1972, the year of its repeal, over 2000 people had been sterilized, many without their consent. The Act was the culmination of years of claimsmaking activities that targeted the province's "feebleminded" population as a growing threat to the social, moral, and economic fabric of society. The Alberta Eugenics Board, a government appointed body comprised of four individuals, was invested with the power to approve sterilizations. This study analyzes the activities of the Eugenics Board and the provincial mental hospitals involved in the social construction of the "threat of the feebleminded". Social construction processes contributing to the construction of the "types" of people who should be sterilized are analyzed through the use of the Minutes of the Eugenics Board, and the patient case file information collected in the province's mental health institutions. This study describes the characteristics of the people who were labeled feebleminded. For example, women were over-represented in sterilizations as were children in the last two decades of the Board's operation. The study also elucidates the ways in which patient characteristics were presented by professionals to substantiate claims made in the public realm regarding the need to stop such "undesirables" from reproducing. The findings indicate that the social construction process emerged out of class, gender, and ethnic stereotypes, and often had little to do with genetic diagnoses. In addition, the social control agencies became powerful entities in their own right and continued to operate long after eugenic theory fell into disrepute. The Alberta eugenics program appears to have been 'successful' for so long because of a combination of political, economic, and social factors, as well as the charismatic leadership of politicians. Concluding thoughts are offered on the implications of the case of Alberta for current genetic research and the idea that eugenics is and should be a contemporary concern.

Dedication

This work is dedicated to the thousands of Albertans who were adversely affected by the activities of the provincial government and its Eugenics Board. While nothing can replace a lost childhood or the anticipation and joy of parenthood, I hope this study helps tell a story that needs to be told.

Acknowledgements

Acknowledging the people whose influence I am so grateful for is a difficult thing. It is impossible, I believe, to truly acknowledge everyone who has helped me complete this work, who has offered their support over the years - who has made this possible. For that reason, I apologize now for omitting anyone in the following list of thanks.

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Chapter One: The "Problem" of Eugenics

> "Should the word *eugenics* be consigned to the
> wastebasket of wrongheaded and pernicious ideas?
> Perhaps it is so tarred that it should be. But the
> judicious use of genetic knowledge for the alleviation
> of human suffering and increase in the well being
> of future generations is a noble ideal, whatever it
> is called." James Crow, 1988 (from Hasian, 1996)

> "$80M and an apology: Victims thrilled as their long
> fight with government ends." (Edmonton Journal,
> Wednesday, November 3, 1999, front page)

In 1959, Leilani Muir, classified as a moron, and therefore eligible for sterilization under the province's *Sterilization Act*, was presented to the Eugenics Board in Alberta and then sterilized. At the time she was told she was having her appendix removed. In 1996, Leilani Muir was awarded $972,800 in damages. She had sued the government for wrongfully committing her to the Provincial Training School in Red Deer, for classing her as a moron, and for sterilizing her. After taking an IQ test in 1989 that revealed that her intelligence was normal, her lawyers began legal action against the province of Alberta to recover damages (*Saturday Night*, June 1997: 32). Her case opened the doors for hundreds of other Alberta citizens who underwent similar treatment at the hands of the government between 1928 and 1972.

Following this precedent, 703 people filed for damages and decided to take the Alberta Government to court for such claims as wrongful confinement, wrongful sterilization, and sexual and physical abuse while institutionalized. The claims totaled $764 million.

On March 10, 1998, the Alberta Government introduced Bill 26 into the Legislature. This bill would have limited sterilization claims against the province to $150,000 each. To protect the government from legal challenges under the Canadian Charter of Rights and Freedoms, the bill invoked the Charter's "notwithstanding clause". This clause essentially exempted the law from the Charter's right-to-sue guarantees (*Alberta Report*, March 30, 1998: 10). The bill caused huge outrage and protests within the province and within less than twenty-four hours, it was dead. After the bill fiasco, several hundred plaintiffs settled out of court. The remaining two hundred settled out of court in the fall of 1999. Eighty million dollars was awarded to the plaintiffs. They also received an apology from the government of Alberta.

How Did It All Start?

> Shall we continue our present system of merely taking charge of the very lowest physical and mental types, those who cause a menace to the state, the feebleminded who in large measure fill our jails and penitentiaries and make up the great sub-stratum of humanity – social derelicts, doomed because of congenital inferiority to lead lives that are crass and unlovely, and to lower the vitality of our civilization? (President of the United Farm Women of Alberta, at a meeting in 1924, arguing for the development of a Sexual Sterilization Act; Christian, 1974: 9)

Planting the Eugenics Seed

Leilani Muir was sterilized because she was orphaned at a time in Alberta history when "problem people" ran the risk of entering a mental health/social service system that used sexual sterilization as a final solution to various social problems. There was nothing illegal about this approach to problem-solving. In fact, beginning in 1928, it was considered legal and necessary to sterilize people considered eligible for such a procedure under the newly enacted *Sexual Sterilization Act*. In order to fully appreciate what was going on in Alberta at the time, we must take a few steps back to consider earlier international developments in eugenics theory and action.

Eugenics theory was a powerful ideological influence in the international scene during the late nineteenth and early twentieth century. The theory promulgated the idea that the 'fit' members of society - the intelligent, successful middle and upper classes - should be encouraged to reproduce, and those 'unfit' - lower class, mental defectives, in other words, the "feebleminded" - should be prevented from increasing their numbers. The goal of the eugenics movement was the improvement or betterment of the race. Informed by Francis Galton's genetic theory and Social Darwinism, the movement's leaders believed that, as with natural selection, those who were the 'fittest' mentally, economically, and socially should be encouraged to survive and reproduce. The end result should be a 'superrace' of sorts. In other words, as with cattle and other animals, humans could also be bred in such a way as to ensure that the healthiest, most productive members of society reproduced. At the same time, 'undesirable' segments of society could be prevented from increasing 'their kind'. Chapter Two will describe in more detail the Alberta scene during this period of history.

The Sexual Sterilization Act

Sexual sterilization legislation was first introduced into the provincial legislature on March 25, 1927. The Honourable George Hoadley, United Farmers of Alberta Minister of Health at the time, introduced the bill, stressing it was much needed. He referred to the increasing passage of such laws worldwide and the need to combat the "alarming increase of defectives" [1]. The Act did not pass second reading, partly because the order paper for the session was crowded but also because the format of the bill had not been clearly planned. As such the Minister of Health pulled the bill, stating he would reintroduce it the following year.

On February 23, 1928 the Act was debated. The Minister of Health initiated the debate by citing statistics regarding the burden on taxpayers in caring for foreign-born inmates in mental institutions as well as referring to other jurisdictions with similar legislation. Several Members of the Legislative Assembly voiced concern and opposition to the proposed Act[2]. The bill, controversial as it was, prompted Premier Brownlee to enter the debate. The bill did manage to pass second reading after much debate and conflict. The turmoil sparked by this passage is reflected in letters to the editor of the two major Edmonton newspapers at the time, as well as the formation of a "People's Protective League", whose goal was to protect the rights of people. The leaders of this group attempted to persuade the Premier to drop the bill, but were unsuccessful.

Alberta's *Sexual Sterilization Act* was passed on March 21, 1928. It allowed for the sexual sterilization of people under the following circumstances: when an inmate was to be discharged from a mental health institution, the members of the Eugenics Board were empowered to examine the person and direct sterilization if it was unanimously agreed that the patient could be safely discharged "if the danger of procreation with its attendant risk of multiplication of the evil by transmission of the disability to progeny were eliminated" (*The Sexual Sterilization Act,* S.A. 1928, c.37; see also Appendix One). The operation could not be performed unless the inmate consented; if the inmate was not capable of giving consent, then a parent, guardian, or spouse had to consent. For those who could not consent, and who did not have a guardian or spouse to consent on their behalf, the Minister of Health was entitled to give consent. The Act also provided for the protection from civil action of physicians performing sterilization operations under the Act.

---

[1] *Edmonton Bulletin*, March 26, 1927.

[2] Timothy Christian's work, *The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act* (1974) details this opposition and the legislative debate surrounding passage of the Act.

> "Trace Defectives To Former Cases" – Ten years ago there were 300 hopeless mental defectives in Alberta. Now, there are 3,000 and 80 per cent of the 3,000 can be traced to the original 300. Since the mental disease act was passed in 1928, 400 sterilization operations have been performed instead of the 2,000 urgently required. A mental defective properly designated as such never recovers. Such were the assertions of the Hon. Dr. W. W. Cross, minister of health in the legislature Wednesday as the house in committee reported for third reading a bill to give a medical board power to compel the sterilization of mental defectives…." (Thursday, April, 1, 1937; Edmonton Bulletin)

Amendments to the Act

Dr. W. W. Cross, the Social Credit Minister of Health in 1937, complained that not enough people were being sterilized under the Act as it stood. He proposed an amendment to the Act that widened its application. The amendment, which was passed, dispensed with the consent requirement for mental defectives and granted the Eugenics Board authority to compel the sterilization of such patients (please see Appendix Two).

In 1942 another amendment to the Act occurred. Again, the intention was a broadening of the category of mental patients that could be directed to undergo sterilization to include individuals "suffering from, -- (a) neurosyphilis with deterioration not amounting to psychosis [and is] not responsive to treatment, or (b) epilepsy with psychosis or mental deterioration," and others "suffering from Huntington's Chorea" (*An Act to Amend the Sexual Sterilization Act, S. A. 1942. c.48)*. In these cases, consent of the patient was required prior to sterilization.

The Eugenics Board

The *Sexual Sterilization Act* provided for the creation of the Alberta Eugenics Board. According to the Act, the Board was to be "comprised of four persons, two medical practitioners nominated by the Senate of the University of Alberta and the Council of the College of Physicians, and two other non-medical practitioners appointed by the Lieutenant Governor in Council" (please see Appendix One). The first formative meeting of the Alberta Eugenics Board took place in January 1929.

In March 1929, at the second meeting of the Alberta Eugenics Board, the Board established a general routine or procedure that would be followed during its quarterly meetings over the next approximately forty-three years. The Board decided that the Superintendents of the various institutions should 'present' cases to the Board and inform the Board of any disagreements regarding the sterilization of each case. Once the Board received the recommendations from the medical superintendents, they would proceed with the case by examining it in terms of the various criteria. The Board also decided that patients should be personally interviewed by the Board before any decision would be made.

Data

The activities of the Board have been recorded in their Minutes[3]. This study analyzes these Minutes (from the 395 Board meetings) in an attempt to answer questions regarding the activities of the Eugenics Board. Other sources of data for the present study include secondary historical sources, along with records from the mental institutions which "fed" patients into the Eugenics Board. Some of the activities of the mental health institutions have been documented in the paper trail left behind. In particular, information for one out of every five individuals "presented" to the Eugenics Board by these institutions is utilized. These data are contained in "case files" which include pertinent information relating to patients' mental health, social development, family history and educational background. Before presentation to the Eugenics Board, the referring institution would compile a "presentation summary" for each patient. Board members would receive a copy of this summary. This 1-2 page document contains information on the patient's family history, medical history, diagnosis, sexual history, personality, social development, educational status, IQ test results, criminal record, ethnicity, religion, age and any other information considered relevant by the institutional staff and/or Board[4].

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[3] These minutes can be examined in the Provincial Archives.

The Approach

What follows is one perspective on the story of the Eugenics movement in Alberta, as reconstructed through these documents left behind by the key players in this drama. In telling this story, I use a social constructionist approach. In taking this stance, my goal is to analyze how it was that "feeblemindedness" was constructed as a social problem. How was it that "mentally defective" and mentally ill people came to carry such weight as a societal menace that needed "fixing"? How did we move from the theory of eugenics as developed by Galton and others, to the creation of the Eugenics Board and the sterilization of over 2800 people? To quote Berger and Luckmann: "How is it possible that subjective meanings *become* objective facticities?" (1966: 17)

A social constructionist approach directs the researcher to account for the social processes leading up to the definition of a social "problem". It directs the researcher to analyze the societal milieu at the time, the claimsmaking activities of key players, and the definition of the problem at various levels. How did institutions contribute to the creation of the problem? How did individuals do so? What were the characteristics of the problematic people? What were the characteristics of the people doing the defining?

Social problems are exactly that - social. In other words, they are the result of social activities – people interacting with one another. Using a social constructionist approach to examine the Eugenics movement in Alberta means analyzing the social activities of the people involved in the process – the interactions that resulted in the events that occurred. This means starting with the historical and social context – interest groups, individuals, and government organization involved in passing the Act. It also means analyzing the activities of the Eugenics Board and the mental institutions feeding into the Board. Finally, it means describing the patients of the

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[4] These presentation summaries can be examined in the Provincial Archives.

Board – who were these people? How did this happen to them? And how did it happen for so long in Alberta?

Most importantly, how it was that before 1928 someone known to be 'feebleminded' had the same rights as someone not so labelled, but after 1928 such a person did not have the same rights? This question, this process – the process*es* that led to the creation of the "*problem* of the feebleminded" is what the social construction of this problem is concerned with understanding.

Another important clarification to make is that while the study is obviously historical in nature since it is based on historical documents, it is not a "historical" thesis as such. The analysis is based on documents and the social construction of a "social problem" as recorded in those documents. It is a textual analysis, but the focus is not on political documents or records of legislative activities; I will not be analyzing the passage or repeal of the sexual sterilization bill. Rather my goal is to analyze documents left behind by the mental health institutions and the Eugenics Board that might shed some light on the ways in which these people constructed the threat of the feebleminded.

The reader might wonder why throughout the study it appears that the Eugenics Board operated in a vacuum, why there is not more emphasis on the Board's interactions with other government agencies, with interest groups and individuals in the public domain. Such an analysis would most certainly be required in a more "historical" study, but again, this study emphasizes the Board's activities as recorded by the Board. From a social constructionst perspective, a textual analysis of documents left behind by the Board should indicate the critical factors contributing to the construction of the feebleminded threat. If there is little or no mention of outside interactions (i.e. interactions with other government agencies and interest groups) this indicates that the Board did not record such interactions. Therefore they are not subject to analysis. If the impression left from a reading of these texts is that the Board and the mental health institutions operated in a vacuum, then one conclusion might be that the Board's perception of itself was one of an autonomous body. An alternative conclusion might be that there were in fact many interactions with outside agencies, that the Board did not operate in a vacuum, but did not record every miniscule detail of such interactions. While the latter conclusion might be the more plausible of the two, the present study does not draw on the historical sleuthing required to establish which is the more legitimate claim. Autonomous body? Or complicated interactions? Again, the goal here is to focus on the construction processes occurring during the Board meetings and recorded in the Minutes and case file information from the mental health institutions.

In analyzing my data sources from a social constructionist perspective, I use quantitative and qualitative methods. Some of the information describing the patients and the Board itself is presented and discussed in terms of numbers and percentages. Other data, for example the Minutes and presentation summaries, are subjected to textual analysis. In reading through and analyzing the narratives left behind by the actors in this historical drama, it is hoped that a clearer understanding can be reached regarding this important story from Alberta history.

There are five main groups of questions that direct the analysis in this study:

1) What was the societal context at the time the *Sexual Sterilization Act* was passed? Who was involved in promoting the eugenics cause? Which social groups were constructed to be problematic?

2) How did the Alberta Eugenics Board operate? How did its activities contribute to a definition of who should be sterilized? In other words, how did the Board itself contribute to the construction of this social problem?

3) Who came under the control of the Eugenics Board? What were the characteristics of the people who were presented and sterilized? Men? Women? Children? Immigrants? And how were these people "controlled"? Institutionalization and sterilization were part of the process, but what were the intricacies of this process? In other words, how did the mental health institutions contribute to the construction of this social problem?

4) Did the Board and the mental health institutions construct the problem in the same way? Were the constructions complementary? Contradictory? What are the implications for social constructionism in general? Can different actors construct the problem in different ways yet still have the same outcome for the groups involved? Did one construction exert influence on the other? Who led this particular "dance" – the Board or the institutions? Were they dancing side by side, or together? Was the dance intricate and complicated? Did everyone know their place in the formations?

5) Finally, why and how did the Alberta Eugenics Board remain in operation for as long as it did?

These five categories of questions direct the analysis. However the overarching thesis, the overall goal, is to understand how this particular "social problem" was constructed, at this particular time in history, by the particular people involved. What was this entity we refer to as *the eugenics movement in Alberta*? How was the problem of eugenics constructed in Alberta? Will an understanding of the social construction of this social problem help us to understand other social problems?

What's to Come

Since we are dealing with a period of several decades in Alberta's history, the next chapter provides a historical look at the international and Canadian events leading up to and influencing the passage of the *Sexual Sterilization Act* in Alberta. Chapter Two also includes more detail on the individuals and groups involved in the eugenics movement in Alberta. It essentially sets the stage for the story that unfolds.

Chapter Three discusses the theory informing this project. Specifically, the constructionist approach is described in detail. As well, the objectives of the study are outlined. This project is not a standard test of a theory in the positivist social science tradition, and so Chapter Three explains and justifies the nature of the study.

In Chapter Four, the data used for the project are described in more detail. There are several data sources, each different yet overlapping in many ways. This chapter also explains the techniques used in the qualitative analyses and links them back to the constructionist approach.

Chapter Five is a descriptive analysis of the people involved in the Alberta eugenics story – the people doing the sterilizing and the people being sterilized. This chapter also describes the techniques used to decide who needed to be sterilized and the methods of control used by the people running the institutions and the Board members.

The Eugenics Board Minutes for the 1930s are scrutinized in Chapter Six, where we attempt to understand the roles played by various people on the Board and in attendance at the meetings, and the techniques used by these people to construct the problem of the feebleminded. The first several meetings in the 1930s were the most "formative meetings" in that the Board set precedents and created administrative techniques for itself. The remaining meetings in the 1930s were also formative in a sense. This was the first decade of operation for the Board, and many issues that emerged during this time continued to plague the Board throughout its operation.

Chapter Seven focuses on the Minutes from the meetings held in the 1950s and 1960s. Did the Board's activities change or stay the same over its four decades of operation? Were different issues addressed in the different decades? Did the construction of the problem at this "official" level of the eugenics movement change over time?

Complementing this analysis is a discourse analysis of some of the case file material available for some of the people presented to the Eugenics Board. This material is analyzed in Chapter Eight. Several "variables" are analyzed as a way of understanding how the institutional staff members constructed the problem of the feebleminded at a perhaps less "official" point in the system. This construction was less official because these institutions were "feeder institutions" without the same type of "official" designation as the Eugenics Board. Both the Eugenics Board and the mental health institutions provide us with information on the construction of the problem – information collected, created, and constructed at different points in the process leading up to sterilization. Comparisons of the construction process between these two different sources might shed some light on substantive, theoretical and methodological issues relating to social constructionism and specifically, the social construction of this particular social problem.

We also look at the ways in which these constructions occurred at different societal levels and how this ultimately contributed to decisions regarding the types of people who were sterilized. Hence it is in these chapters where the many parts of the story come together.

Finally, Chapter Nine summarizes the findings and draws some conclusions regarding the eugenics movement in Alberta. One is left wondering: "Why did this happen? Why did it happen in Alberta? And why did it continue for so long?" The concluding comments attempt to answer these questions.

Chapter Two
Setting the Stage: The Historical Context

There were important trends occurring on the world scene prior to the passage of the *Sexual Sterilization Act* in the 1920s in Alberta. This chapter is intended to set the stage, so to speak – to describe in some detail the social and cultural milieu of the time. The historical events and social developments of the late 1800s and early 1900s had a significant influence on the creation and momentum of the eugenics movement in Alberta.

Eugenics was not only popular in Alberta. Perhaps the most well-known example of eugenic social engineering occurred in Nazi Germany, where thousands of people were sterilized in an effort to 'cleanse' the German population (Proctor, 1988; Usborne, 1997). Yet, around the world we find other examples, perhaps not as large-scale, of similar movements and policies (Gosney and Popenoe, 1929; Reilly, 1991). Much has been written on American sterilization campaigns in the late nineteenth and early twentieth centuries, where groups referred to as "the dependent, defective, and delinquent classes" (Rafter, 1992: 17) were targeted by government policies. These policies involved either incarceration during childbearing years or sexual sterilization.

But little has been written about similar policies in Canada. Specifically, the case of the Alberta Eugenics Board, for the most part, has eluded examination. Yet, this case offers an illuminating look at the eugenics movement in a country that has often been applauded for humane treatment of its citizens. This chapter examines the case of the Alberta Eugenics Board, its relationship to the Alberta provincial government, and the involvement of certain interest groups in the development of eugenic policies.

When studying a "social problem" such as the eugenics movement in Alberta, one might ask who played a key role in constructing the "problem" of mental defectives and the mentally ill? Who felt the necessity to implement the *Sexual Sterilization Act* of 1928, which allowed for the sterilization of hundreds of institutionalized individuals? Who was able to take these claims and rally support within the province and within the government? What sorts of responses were received for these claims? Why was there no outcry against the claims, and if there was, why was it not as influential as the cry for sterilization? Why did claimsmaking in Alberta result in the *Sexual Sterilization Act*, while similar claimsmaking activities did not have the same result in, for example, Ontario? These are important questions that are explored below.

The changing nature of the Alberta scene, as well as that of Canada and world scene, during the late 1800s and early 1900s helps to explain the birth of both the Canadian eugenics movement and the Alberta government policies that resulted. Several important factors set the stage for the movement, the first of these being scientific developments.

Scientific Developments

In 1919, W. L. Lochhead, a professor of botany in Canada, published an article in the *Canadian Bookman* which introduced Canadians "to the complexities of the new science of genetics" (McLaren, 1990: 13). This new science, he argued, would not only improve plant and animal breeding, but would also improve human reproduction.

> This latter phase is called Eugenics and has received considerable study, the result going to show that human characteristics behave in a Mendelian manner, and that it is quite possible to improve upon existing methods of production of human beings. Many careful investigations of family records reveal the fact that both good and poor qualities are inherited according to Mendelian laws. Many defects such as feeble-mindedness, epilepsy, deaf-mutation, and disposition to tuberculosis and other diseases are undoubtedly inherited, and to put no hindrance to the breeding of unfit and degenerate persons exposes our country to the gravest risk of regression, especially when it is recognized that the population is being largely recruited from inferior stocks (Lochhead, 1919 in McLaren, 1990: 13).

This view was influenced heavily by the work of Britain's Sir Francis Galton, who first coined the term 'eugenics' in 1883. Galton used the term "eugenics"

> to describe the study of the agencies under social control that may improve or impair the racial qualities of future generations, either physically or mentally, and asserted that the statistical approach, if used to encourage such selective breeding, could

solve the social ills that beset Britain (McLaren, 1990: 15).

He believed that intellectual capacity was determined more by nature than by nurture, in the predominance of heredity over the social environment (McLaren, 1990: 14). During this time Mendel's theories regarding dominant and recessive genes and the passing of characteristics from one generation to the next were revived. Though there were differences between the Galtonian biometricians and the Mendelian-minded biologists, both groups were able to convince the public that there was scientific agreement that heredity was determined to be more important than the environment (McLaren, 1990: 17). This change in scientific view signaled an abandonment of the nineteenth-century belief in progressive reformism which held that the environment predominated over nature.

Ideological Changes

"The growing success of eugenics in popularizing fears of degeneration was a symptom of a decline of faith in nineteenth-century liberalism" (McLaren, 1990: 17). Previous to the rise in popularity of eugenics theory and policy, there reigned a laissez-faire mentality toward not only the economy, but toward population and society as well. Informed by such thinkers as Herbert Spencer, and his term "survival of the fittest", the accepted mode of thought was that over time, as with Charles Darwin's evolution of species, society too would evolve. During the course of this evolution, the weaker members of society would die out. Such an attitude fit in well with the current belief in the competitive nature of society, with its increasing specialization, differentiation and interdependence. "Those who were poor and unsuccessful had, the theory went, proven themselves unfit for the struggle and would, by the free working of natural laws, be removed from the contest" (McLaren, 1990: 17).

Prevailing population theories at the time also pointed to the natural establishment of equilibrium over time. As such, all one could hope for was to understand the 'laws' of population: "such laws could not be countered by institutional interference" (McLaren, 1990: 17). Even "old-fashioned social Darwinists were true to such beliefs and willing to let the struggle for existence continue" (McLaren, 1990:18). The eugenicists, however, had a different plan. Informed by population studies of the

1880s which showed that the 'unfit' were reproducing at a faster rate than the 'fit', these social planners decided it was time for intervention. It was apparent to the eugenicists that rational self-interest was not working to eliminate the poor. Rather it was heredity that determined the quality of the population. In response to these "discoveries", "the eugenicists argued that decisions on breeding could no longer be left to individual whim or chance; an outside agency was required to monitor actions that affected the entire community" (McLaren, 1990: 18).

The eugenicist scientists were not the only ones who held this "interventionist' perspective when it came to solving social problems. Politicians, social scientists and other notable members of society, influenced by the industrial revolution and its attendant belief that man had control over progress, also believed in the potential for social engineering to solve the social problems of the day.

Class Concerns

The industrial revolution led to the creation of greater class inequality. With greater class differences, the lower classes became a source of fear for middle and upper classes. Informed by hereditary thinking, the popular belief was that "the poor were not demoralized; they were degenerate" (McLaren, 1990: 19). In other words, class differences were not the result of poor working and living conditions that resulted from industrialization and urbanization. Instead, these differences were the result of poor heredity and degeneration within the rapidly reproducing lower class. Previously it was thought that, since lower class status was the result of individual moral flaws, this could be fixed by showing the lower classes the error of their ways. Now, however, since lower class status was a hereditary problem, the eugenicists offered a relatively simple solution: control the breeding of such undesirables and the problem of the lower class would be solved.

Anti-Feminism and Eugenics

Among eugenicists there was also a belief that feminism posed a threat to their movement. Specifically, the use of birth control among the 'better' women in society meant that these 'fit' individuals were not doing their societal duty, namely, reproducing. More intelligent and educated women were more apt to control the sizes of their families, while the less fit, poorer women were reproducing at higher rates because they were ignorant of birth control measures. "In the eyes of the hereditarians the greatest anti-social act committed by the better type of woman was the avoidance of pregnancy...the finer females, in restricting family size, were snuffing out strains of hereditary intelligence" (McLaren, 1990: 21).

The eugenicists believed that woman's role was determined by her biology, by her reproductive function and her reproductive responsibility to society and to the race. Although feminists were beginning to argue for equal rights with men, "the eugenicists replied that sex differences were based on biological facts that could not be overridden by appeal to justice...Biology, not politics subjected her to man" (McLaren, 1990: 20). Furthermore, according to eugenicists,

> If she was unhappy the answer was not to wrench her from her natural calling and plunge her into an unequal contest from which she could only emerge defeated and embittered; the answer was to provide her with the support necessary to permit her to fulfill more adequately her function as childbearer (McLaren, 1990: 20).

It was argued that higher education for women was a two-edged sword; it could either raise their intelligence or it could lead to their degeneration. Hence, it was necessary for the feminists to promote their ideas with caution. One particularly vocal anti-feminist eugenicist, in writing about the 'dysgenic consequences' of women's education, said that "'women's rights' could only be considered after those of, first, mothers, and second, fathers" (McLaren, 1990: 22).

'Positive eugenics' (encouraging the reproduction of 'fit' members of society) encountered problems in that it was more difficult to determine who should reproduce than it was to point to those who were obviously defective and therefore should not reproduce. Eugenicists, as a result, turned more to 'negative eugenics', which involved the segregation and sterilization of undesirable members of society (McLaren, 1990: 23).

Early Eugenics in Canada

The ideas that were being promoted abroad were quick to gain popularity in Canada in the early 1900s. Nova Scotia, in 1908, saw the first "eugenics movement" in Canada when the League for the Care and Protection of Feebleminded Persons was formed in the province (McLaren, 1990: 24). In Quebec, academics at McGill University seemed intent on promoting the eugenics agenda. Here, and in other provinces, professors and doctors played key roles in recruiting British hereditarians to their ranks and in publicly supporting eugenic ideas. Dr. Helen MacMurchy was particularly influential in promoting public health and, specifically, eugenics ideas in Ontario. She was perhaps the most vocal proponent and activist for eugenics in Canada.

As McLaren (1990) states, the western provinces, particularly British Columbia and Alberta, provided a receptive and hospitable climate for eugenic ideas and hereditarian doctrines. Why this was the case is an important and interesting question that is addressed in a later chapter. In British Columbia, Alice Ravenhill, an expert in household science and child hygiene who played an active role in English eugenics, promoted eugenic ideas through the *Women's Institute Quarterly* (McLaren, 1990: 26). In Alberta, university courses became important forums for dispensing eugenic ideas. It appeared that, by the early 1900s, the Eugenics movement had found a home in Canada, and specifically in the Canadian West. Consensus was building that something had to be done to encourage the fit to reproduce while restricting the defective from continuing to contaminate the human race.

Thus far we have seen how the ideas of Francis Galton, Canadian academics and physicians, Western Canadian promoters, anti-feminists, and the political elite (see Simmons, 1982:59) contributed to a redefinition of who was to be the new threat to society and the betterment of the human race. This movement resulted in a changing consensus within the population at large. It also promoted the idea that something could and should be done about the increasing social problems of the time, problems that could be linked to the 'hereditarily faulty'. The tactics used to influence public opinion included academic debate, scholarly works, social investigations and university courses. More importantly, the people leading these movements relied on an appeal to the economy and to the need for efficiency in the running of the country. They promoted the idea that the hereditarily weak component of society was responsible for the woes of the day. But they also stressed that there was a scientific solution to this problem.

We turn now to a discussion of the political groups and institutions involved in the creation and promotion of the *Sexual Sterilization Act* in Alberta, the tactics used by these groups to gain ownership of the "problem" and have their views promoted, the ways in which they influenced policy, and the methods used to ensure their survival.

Interest Groups

But first, we must briefly consider two basic approaches that explain why it is that deviance exists in society. Functionalists argue that crime and deviance both provide boundaries within which society's members learn to behave (Durkheim, 1984). Group norms are enforced and strengthened by the existence of deviants. It is in a society's vested interest to create categories of deviance so that it can sustain order and consensus. Essentially, "societal integrity is dependent on moral consensus" (Sutton, 1991: 669). This view "treats deviance as a reflex of social structure" (Sutton, 1991: 669). Further to this, "those individuals or groupings of individuals that are actually punished will not necessarily 'deserve' it; their punishment, however, will be perceived as necessary for the benefit of society" (Tittle, 1994: 24). Who gets punished? And, perhaps more importantly, who decides who gets punished?

Punishment, ostracism, or some type of labeling can also be the result of power differentials in society. The conflict perspective sees deviance and crime as closely intertwined with the distribution of power resources, political and economic (Conklin, 2001; Taylor, Walton, and Young, 1973). This perspective on deviance argues that the decision regarding who is to be defined as deviant and/or criminal rests on the shoulders of those who control power and wealth in society. Law thus reflects the will of the powerful and well-to-do. Behaviour that threatens the interests of the elite will be punished and controlled. While much of this work addresses the sanctioning of criminal behaviour, such as theft and assault, the conflict approach also addresses issues of more 'subtle' forms of deviance. In other words, instances of deviant behaviour, characteristics, or ideas also fall under the rubric of the conflict perspective.

For example, Communist thought might be seen as threatening to the interests of capitalists in Western democracies. Likewise, deviant sexual behaviour might be viewed as threatening to the moral order, which is often closely tied to the beliefs and standards set by those with the power to do so. In this sense, "feeblemindedness", which encompassed "mental defectiveness" and mental illness, if constructed as dangerous and threatening to the powerful, would require a "solution".

According to Sutton (1994) the cultural and political levels in society meet in the production of deviance and social control when "political actors appropriate cultural symbols of deviance and normality to legitimize policies of social control...as policies become institutionalized, they feed back into culture" (242). In empirical studies of such situations, we need to focus on "the organizational sites where symbols are infused with power" (242). Such organizational sites include groups of moral entrepreneurs, professional groups, voluntary associations, the state and its bureaucracies, to name a few. More specifically, Sutton points to two broad foci for such an analysis. First, the state itself and the "relative vulnerability of various political regimes to transient moral panics" (243) should be a focus. Secondly, private sector interests and the appearance of such groups need to be systematically understood in order to more fully understand the creation of deviance and the social control mechanisms needed to deal with such deviance. It is within these organizational sites where we start with our analysis of the eugenics movement in Alberta.

Progressives, Social Gospellers and Labour Groups

While eugenics was gaining popularity in other parts of the world (i.e., Britain), a social climate conducive to such a movement was in the making in Western Canada. Between 1900 and 1916, conditions were ripe for the promotion of eugenics ideas in the West. During this time groups of reformers such as the Social Gospellers, Progressives and women's suffragettes "advocated a philosophy of progress based upon the application of science to society which in this instance was eugenics" (Chapman, 1977: 9). From 1900 to 1916 a belief had been building in the public mind that science had the answer to the problem of improving existing social conditions.

Many of the issues raised by the reformists were the indirect result of Canada's industrialization and urbanization. Concomitant with these changes came an increase in immigration - people were needed to work, not only in agriculture, but in the factories in the cities - and a resultant concentration of "ethnics" in the poorer sections of Canadian cities. Such concentrations could only contribute to already growing racial differences and prejudices (Chapman, 1977: 9). As a result, immigrants and immigration policies became a focus of reform attempts.

Labour groups in the West opposed unrestricted immigration policies because this meant a cheap labour pool from which employers could draw workers. But their opposition was not very successful. The result was a mobile immigrant labour force in the West that worked under poor conditions and for little pay. Business and government, on the other hand, were in favor of such a mobile, cheap labour force, and therefore favored unrestricted immigration policies.

But labour was not the only sector of society that had a vested interest in the "immigrant issue". Canadian churches also took it upon themselves to get involved in the lives of the newcomers. Their tactics in dealing with the foreigners were twofold. The first approach was one of assimilation. "To understand the 'conventional' churches' response to the foreigner, however, it is essential to remember that Canadianization was synonymous with Christianization" (Chapman, 1977:10). Christian missions were established in the city slums, where most of the immigrants lived, in an attempt to begin the process of assimilation. In the meantime, however, the second 'religious' approach to dealing with the immigrants was "evolving within the boundaries of western Canada and the confines of the conventional Protestant churches".

> This radical response was later to see some of its proponents leave their respective church circles to delve into the radical social gospel, labour radicalism and communism. Initially attempting to segregate the undesirable immigrant, this offshoot response came to demand segregation, and later sterilization of those elements in western Canadian society deemed inferior and thereby unwanted (Chapman, 1977: 10).

These religious groups were turning to scientific measures as a means of assuring the development of western Canada. It is also obvious that the two responses to immigration – assimilation, and segregation and sterilization, are completely incompatible goals (Chapman, 1977: 10). "The purpose of assimilation was to Canadianize the hordes of foreigners, while segregation and sterilization were the means to ensure that Canada would forever remain white, Anglo-Saxon, and Protestant" (Chapman, 1977: 10). There was a general air of superiority for "Canadian" customs, beliefs and institutions and one of inferiority regarding foreign ethnic groups.

This general feeling within the Canadian public resulted in some tightening of immigration policies. However, vocal reformers, such as J. S. Woodsworth, who is discussed in more detail later, pushed for reforms that would have immigrants carefully screened, physically and morally, before leaving their home country. Many middle class Canadians felt that immigrants, with all the medical testing they required and the help they needed to get set up, were becoming a heavy tax burden. This resulted in a 1909 Order-in-Council which stipulated that every immigrant must have a certain amount of money in their possession to be permitted into Canada (Chapman, 1977: 12).

Moral Entrepreneurs

Moral entrepreneurs and social reformers also became heavily involved in the campaign against immigrants and for sterilization. "In the minds of social reformers, the problems of unrestricted immigration were further manifested in the bars, brothels and opium-joints which seemed to flourish in western Canada's urban centres" (Chapman, 1977: 13). It was the attitude that immigrant groups came from "inferior stock" that made it easy for the social reformers to associate them with alcohol and opium. In other words, "alcohol was the social disease of the southern European, and opium, the achilles heel of the Oriental" (Chapman, 1977: 13). "By definition, 'the reputable' became those individuals who would not indulge in illicit practices, while 'the disreputable' immigrant would, by his very nature, be a participant in such behaviour" (Chapman, 1977:13).

While segregation was being used, the appeal of sterilization became increasingly more important to the reformers. The notion that criminality, alcoholism, and epilepsy, as well as intelligence, were hereditary in nature, gave the reformers the impetus to consider and study sterilization as an effective alternative to segregation, one that might prove to be a more efficient means of social control. The result was the creation of a Bureau of Social Research by the governments of Alberta, Saskatchewan, and Manitoba (Chapman, 1977: 13). The Bureau is discussed in detail below, in the section on the bureaucratic influence on sterilization.

Professional Groups

Professionals are another group that played an important role in the eugenics story, particularly professionals in the social services domain. This group includes medical personnel, mental health professionals such as psychiatrists, and also social workers. We see in later chapters that they surface again and again as key players. While they did not play as central a role as other groups in the claimsmaking activities that led up to the passage of the *Sexual Sterilization Act*, they certainly contributed to its longevity as a piece of legislation.

Because the *British North America Act* of 1867 had nothing to say about health and social services, municipal and provincial governments had to step in and create such systems on their own. Initially, from the 1900s to the 1920s or so, such services tended to be provided by charity groups. With increasing urbanization and industrialization, increasing social problems, and the Depression, it became obvious that the existing system did not address the needs of the people. "The experience of the 1930s showed conclusively that the pattern of public and private social services which had emerged by the end of the 1920s was totally inadequate to meet the needs of the Canadian people" (Meilicke and Storch, 1980: 52). By this time, governments recognized that social services, child guidance clinics, and mental health services in general were sadly deficient. By 1947 a scientific and professional social services sector in Canada was developed and promised to become more dominant over the next several decades (Meilicke and Storch, 1980: 60).

It was during this time period that social work programs developed in various universities throughout Canada – at the Univeristy of Toronto in 1914, at McGill in 1918 and at the University of British Columbia in 1928. After the Second World War, the federal government began utilizing professional workers for various purposes (Meilicke and Storch, 1980: 60). Finally, as Cassidy wrote in 1947, and as additional evidence of the burgeoning of social service professions during the reign of the Eugenics Board:

> Recently the Dominion has recruited a number of the best professional workers in Canada for the new departments of Health and Welfare and of Veteran's Affairs. In the meantime there has been distinct progress in building up professional staffs in several provincial welfare departments and in a few of the cities (Meilicke and Storch, 1980: 60).

Later we return to the significance of the "professionalization of social control" during this time period and the crucial contribution this process made in terms of the longevity of the *Sexual Sterilization Act*. For now, the goal is to illustrate that the mental health and social work professions were growing rapidly during the 1940s and 1950s. In addition, I make the argument later that professionals played key roles in ensuring that the eugenics movement continued by playing key roles in the province's mental health institutions. As evidence of this we find again that in 1947 professionals were assuming leadership position in the administration of the social services (Meilicke and Storch, 1980). Cassidy, voicing what appears to be the view of the time, continues by lamenting the current state of social services and the need for expansion and development in the area. In addition, he predicts that there will emerge major advances in the social service field.

Thus, shortly after the creation of the *Sexual Sterilization Act* in Alberta, the social services profession began to grow, in terms of development of training schools, in numbers of social workers and other professionals graduating, in numbers of positions created, and in the power and credibility given to such professionals. Morgan, writing in 1961, concludes that "the emergence of social work as a discrete profession with its own professional organization, and an established academic discipline of study and research has been a mark of the second quarter of the twentieth century" (Meilicke and Storch, 1980: 97). We see later that the second quarter of the twentieth century was also characterized by increasing activity on the part of eugenicists in Alberta.

We turn now to a discussion of the involvement of private citizens in the campaign for eugenics in Western Canada, and specifically, in Alberta. These people were particularly influential in helping to complete the construction of the image of the "mental defective/immigrant as enemy".

Individual Activists/Movement Leaders

J. S. Woodsworth

One of the most active proponents of eugenics was a left-wing Social Gospeller by the name of James S. Woodsworth. He was Superintendent of All People's Mission in Winnipeg, and was a proponent of the assimilation doctrine. He conducted and published studies on immigration and its social response. Perhaps most influential was his work entitled *Strangers Within Our Gates* (1909). This book

> serves as a basis for an examination of but one Canadian response to the immigrant. This reaction can only be defined as a eugenics program for it promoted a policy of outright segregation and the suggestion of a sterilization program (Chapman, 1977: 11).

Woodsworth was particularly concerned about the change in 'quality' of immigrants that occurred around 1882. And he translated this fear into a public crisis of sorts. He spread the idea that no segment of Canadian society would be left untouched by the influx of unrestricted immigration of such 'inferior' stock. Apparently there were different qualities of immigrants with Scandinavians and Icelanders being 'clean-bodied' and 'serious-minded as a race', and Slavs and Galicians being 'addicted to drunken sprees' and 'animalized' (McLaren, 1990: 47). He was definitely an ardent supporter of stricter immigration laws, despite the fact that Canadian immigration laws at the time were already fairly restrictive.

Woodsworth's 'campaign' turned more to sterilization and eugenics as time went on. In writing *Strangers Within Our Gates*, he drew heavily on eugenic philosophy (Chapman, 1977: 12). His methodology and factual analyses were in large part influenced by the work of Prescott Hall, who wrote the following about immigrants: "They are the defective and delinquent classes of Europe - the individuals who have not been able to keep the pace at home and have fallen into the lower strata of its civilization" (Chapman, 1977: 12). As Chapman states in reference to Woodsworths' urging of Western Canada to establish a school of eugenics:

> Woodsworth's eventual support of a sterilization program appeared to be the result of a deep-seated frustration in coping with the complexity of the immigration problem. Thus, a simple prejudice against the foreigner was transformed into an acceptance of a eugenics program (Chapman, 1977: 13).

Emily Murphy

Woodsworth was not the only upstanding Western Canadian citizen who was concerned about the immigration "problem" and the problem of "defectives" in general. As Chapman states, "the campaign for eugenics through sterilization was given further impetus in Alberta when Judge Emily Murphy stated that in Alberta alone, 'seventy percent of the patients in our mental hospitals were born outside Canada'" (1977: 15).

Emily Murphy, considered a vanguard of negative eugenics, furthered the goals of the National Committee for Mental Health in various ways. Besides being a prolific and influential writer and public persona, as well as a well-respected Magistrate, she spoke to specially organized meetings and to women's groups. At such meetings she would show films of the inside of institutions, and then she would talk about mental illness and its causes. After such an address to the Medicine Hat Women's Council, the Secretary of the group, Mrs. J. R. James was instructed to write a letter to then premier of Alberta, J.E. Brownlee, strongly advising the Government to give full consideration to Murphy's sterilization proposals (Christian, 1974: 11). Murphy quoted Dr. Goddard as saying "Every feeble-minded person is a potential criminal" (Christian, 1974: 12).

Murphy was an accomplished author and this helped her to publicize her views on sterilization. She wrote an article entitled "Should the Unfit Wed?" for a widely circulated newspaper (the *Vancouver Sunday Sun*). It has been said that the article is a "propagandistic masterpiece" (Christian, 1974: 12). Here are some excerpts from the article:

> Whenever a man who is not in a side-show eats his blanket or the plaster off the wall, plucks his hair bald, or turns himself into an immobile statue that neither speaks, sees nor hears, you may have serious doubts as to his sanity. There are many other signs of the S.P. – that is to say the Suspected Person....but these are fairly characteristic. You must never forget, however, that when these insane persons are released from durance, they are quite free to become the parents of more and many children...(Christian, 1974: 12)

In urging the adoption of a eugenics program, Murphy goes on to warn that

> ...the congenitally diseased are becoming vastly more populous than those we designate as "the upper crust". This is why it is altogether likely that the upper crust with its delicious plums and dash of cream is likely to become at any time a mere toothsome morsel for the hungry, the abnormal, the criminals and the posterity of insane paupers – in a word, of the neglected folk (Christian, 1974: 12).

While we can never know exactly what contribution the writings and opinions of Emily Murphy made in laying the groundwork for the passage of the *Sexual Sterilization Act*, we do know that she was an extremely well-respected and influential member of Alberta society in the 1920s and 1930s (Christian, 1974: 12), and she actively promoted her beliefs during this time.

Dr. C. M. Hincks

Dr. Clarence Hincks, professor of Psychiatry at the University of Toronto, and General Director of the Canadian National Committee on Mental Hygiene (CNCMH), conducted a "Mental Hygiene Survey of the Province of Alberta" which was published in 1921 (Christian, 1974: 3). The survey examined the relationship between "mental abnormality and social inefficiency" and reviewed provincial facilities for the mentally abnormal. The study found what the authors perceived to be a link between mental abnormality and immorality. In addition, they found that mental abnormality and delinquency correlated with illegitimacy, prostitution, and dependency. Christian points to the self-fulfilling prophecy nature of the Committee's research method and results. The Committee administered IQ tests to "problem" elementary children and found them to have lower I.Q.s . This was before the time when IQ tests were recognized as being culturally biased. Since many of the students during this time were likely immigrants or first generation Canadian citizens, this criticism of I.Q. tests becomes particularly relevant. The surveyers also interviewed these "troublesome" children - to confirm the existence of less sound moral values (in addition to lower IQs) among these children. As a result, "bad behaviour and sexual immorality were seen to be directly related to mental deficiency" (Christian, 1974: 5).

Hincks, in charge of the Committee and its survey, was a key figure in the national campaign for the sterilization of the unfit. He and his Committee were quick to point to a connection between feeble-mindedness and immorality and crime. "In particular they asserted that the recent wave of Slavic immigrants suffered from high levels of feeble-mindedness, a finding enthusiastically hailed by Anglo-Saxons" (McLaren, 1990: 99). This was the impetus for groups such as the United Farmers of Alberta to proceed full-force with the already growing sterilization movement.

Social Constructionist Techniques Used by Individuals

Woodsworth and Murphy were particularly adept in their use of propaganda and melodrama. Woodsworth referred to immigrants as "inferior stock"; he claimed that "no segment of Canadian society would be left untouched" (Chapman, 1977: 11). Murphy did her part too, in such statements as the following: "there were more people in the Mental Hospitals of the Dominion than in the general hospitals put together" (15). Such beliefs were further promoted through popular magazines like the *Grain Growers' Guide* and the *Farm and Ranch Review*, which published comments like: "the good seed alone should be allowed to enter and the chaff should be returned to its original dwelling place. Let us not work too hard for quantity, but rather for quality" (Chapman, 1977: 13).

Reformers such as Woodsworth, a preacher, and Murphy, a judge, were prolific writers, well-versed in the use of the media and the written word, metaphors, and rhetoric in promoting their ideas. They published articles in popular magazines and spoke at public meetings. The construction of the social problem of mental defectiveness and immigrant status was aided through the criminalization of feeblemindedness and immigrant status. People labeled as feebleminded were assumed to be more involved in criminal activities, as were particular groups of newcomers to the country. Through the written and spoken word, and the presentation of scientific results of surveys, it became an accepted belief that mental deficiency and immorality were synonymous.

Political Groups Involved

The CNCMH

The Canadian National Committee for Mental Hygiene was established in 1918. As mentioned above, Clarence Hincks played in influential role in the eugenics movement in Alberta. The goal of the CNCMH was to launch a campaign against crime, prostitution, and unemployment, which it claimed were all related in some way to feeble-mindedness (McLaren, 1990). The Committee's founders were of the belief that the old system of dealing with the feebleminded - institutionalization - was ineffective. A new, effective approach would be preventative in nature and would begin with the examination and testing of potential clients (McLaren, 1990: 59). "One of the primary purposes of the CNCMH was to survey, investigate, report and advise in matters of health, mental hygiene, social welfare and social control" (Park and Radford, 1998: 319). Dr. Hincks, and the CNCMH was commissioned to survey the western provinces in order to "ascertain the magnitude of 'feeble-mindedness'" (Park and Radford, 1998: 319). In Alberta, especially, it seems that the mental health survey conducted by Hincks played a significant role in the eventual enactment of the *Sexual Sterilization Act*. "The Committee provided anti-immigrationists with added ammunition by asserting that its surveys proved that there was a direct correlation between immigration and insanity, criminality, and unemployment" (McLaren, 1990: 59). This, in Alberta at least, seemed to be all the various groups and individuals advocating sterilization needed to back up their arguments. With such information in hand, they were able to more actively pursue their eugenics agenda, with the 'proof' of the 'scientific surveys' to back them up.

The U.F.A. and the U.F.W.A.

In March 1927 the Minister of Health in the United Farmers of Alberta Government introduced into the legislature a bill that would provide for the sexual sterilization of mental defectives. The bill did not pass second reading, but the Minister announced he would reintroduce the bill in the 1928 session. The government appears to have attempted to pass the bill in response to strong pressure from many community leaders and influential organizations before they had worked out the precise format the bill should take (Christian, 1974: 2).

Specifically, in 1922, in response to the recommendations of the survey conducted by Dr. C. Hincks, the United Farmers of Alberta passed several resolutions at their annual convention. These resolutions, sent to the UFA by the United Farm Women of Alberta, urged the government to draft and enforce legislation to allow for the segregation of feebleminded adults during their reproductive years, and also suggested a study should be conducted regarding sterilizations and eugenics (Chapman, 1977: 15; Christian, 1974: 8). The Minister of Health at the time, the Honorable R.G. Reid, stated that sterilization would be the preferable option, but that first strong public sentiment in support of such a measure should be developed (Christian, 1974: 8).

The United Farm Women of Alberta were particularly active in developing this support. In 1924 the group organized a campaign that contributed to the eventual passage of the *Sexual Sterilization Act*. In her 1924 presidential address, Mrs. Margaret Gunn encouraged the government to pursue a policy of "racial betterment through the weeding out of undesirable strains" (Christian, 1974: 9). As Christian points out, "She brushed aside civil libertarian opposition by arguing that 'democracy was never intended for degenerates...'" (1974: 9)

In 1925, the UFA adopted a resolution at their annual convention that required sterilization of mentally deficient people. At their 1926 annual meeting, the UFWA made a recommendation making it compulsory for all persons to undergo a medical examination prior to marriage (Christian, 1974: 9).

When the Act was reintroduced and passed in 1928, the United Farm organizations had achieved their goals. The UFWA, at their meeting in 1929, heard the following report from the chairman of the Health Committee:

> The intelligent interest of our members, and the careful thought and study which they gave to this problem, culminating in a remarkable unanimity of opinion, materially assisted the Government in the fairly happy passage of the Act (Sexual Sterilization Act) through the legislature (Christian, 1974: 10).

Bureaucratic Groups Involved

Bureau of Social Research

The provincial governments of Alberta, Saskatchewan, and Manitoba together created a Bureau of Social Research. The Bureaus were commissioned to study a variety of topics including child welfare, anti-crime legislation, rural communities, and "mental defectives". The Bureau, strongly influenced by J.S. Woodsworth who was a member of the Board, published and circulated many articles concerning the problem of the "mental defective" in western Canada. The Bureau, in its research and writings, placed mental defectives into four categories: idiots, imbeciles, the feebleminded, and moral defectives (Chapman, 1977: 14). In this way, immigrants could easily be placed into a category, while "Canadians", who were at least physically and mentally superior, could be placed in the moral defective category if need be. The Bureau, under the influence and direction of Woodsworth, focused much of its writing on immigration and racial differences. The Bureau also supported the eugenic belief that mental defectiveness was hereditary. However, it extended the hereditary notion further to argue the hereditary basis for alcoholism and drunkenness. These pronouncements by a government-based research branch gave impetus to the already developing temperance and prohibition movement (Chapman, 1977: 14).

The Bureau played an active part in urging the government to take action in the segregation and sterilization of defectives. The Bureau maintained that "the state itself must assume the responsibility and enact laws against the marriage of defectives to ensure the prosperity of the Canadian people" (Chapman, 1977: 15). However, the Bureau recognized that while such ideas were in the best interest of the Canadian public, the public was not yet ready to fully support such policy. So, it continued with its role as research agency and public dispenser of eugenics-favourable information until the public was ready to push for appropriate legislation. With such rhetorical techniques as the following, it continued to influence popular opinion in creating an image of the inferior stock who were contributing to the demise of Canadian society: "Mental defectives are here in hundreds, they are multiplying rapidly, more are coming in every ship load of immigrants" (Chapman, 1977: 14).

So far we have looked at the historical developments that contributed to the eugenics movement. We have also seen that several groups and individuals were actively involved in promoting the eugenics cause. Next, we must look at the developments that occurred in the province of Alberta which made the Eugenics Board and the sterilization of hundreds of people a reality.

In the case of the eugenics movement, it was generally the poor, the immigrants, the less well adjusted, socially and intellectually, who became targets for the deviant label. The more intellectual, 'fit', scientifically 'informed' members of society, who also often held powerful positions as leaders of political organizations, became the definers, the labellers, and the social controllers. Earlier we saw evidence of how individuals were defined – they were "deficient" mentally and physically. They were morons, criminals, drug addicts. We come back to these definitions in the following chapters.

Eventually, after the hard work and campaigning done by the various groups and individuals described above, the *Sexual Sterilization Act* was passed in March, 1928. Its main points were described in Chapter One. The final "definers" of the problem were the Eugenics Board members. At their meetings, held approximately four times a year, patients were brought before the Board members and were interviewed. If patients were too "disturbed" to be brought to the meeting, the Board might visit the patient on his or her Ward in the mental institution. Regardless, it was at these meetings, these "interactions" between individual patients and Board members, where the final decisions to sterilize were made. In Chapter Five, we see in more detail who these individuals were, the "labellers" and "labellees".

The initial Board members were Dr. E. Pope (Edmonton), Dr. E. G. Mason (Calgary), Dr. J. M. MacEachran, the Provost of the University of Alberta, and a secretary, Mrs. J. W. Field[1]. MacEachran remained Chairman of the Board from its inception up until 1965, when he retired. The other Board members were eventually replaced; Board turnover generally, was minimal. In other words, it seemed to take illness, death, or war for a Board member to step down from his/her duties. This is discussed in more detail in later chapters.

As we saw in Chapter One, Amendments to the Act eventually served the purpose of bringing more and more individuals under the control of the Eugenics Board. The Amendments also served to bring different people under the domain of the Act. Things changed over time. The first Amendment to the Act (1937) mandated that mentally defective people did not have to consent to sterilization. A second Amendment (1942) resulted in people "suffering from, --a) neurosyphilis with deterioration not amounting to psychosis [and is] not responsive to treatment, or b) epilepsy with psychosis or mental deterioration, [and others] suffering from Huntington's Chorea" (*An Act to Amend the Sexual Sterilization Act*, 1942) being brought under the jurisdiction of the Board. There was nothing static about the way in which the "problem populations" were defined. In fact, the changing social construction regarding which people were the problem becomes an important issue in Chapter Five.

Also, as we will see later, the initial Board composition changed (due to death, illness, and war) over the course of time. Although the initial Chairman of the Board, James MacEachran, remained in control from 1929 to 1965, other Board members came and went. However, despite the long reign of the Board (1929-1972), there was in fact less turnover than one would expect. Over the entire period during which the Board was in operation (1929-1972), only twenty-one Board members were involved. And there were only two Chairmen of the Board during this entire period.

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[1] Mrs. Field was an active and ardent supporter of the sexual sterilization of 'misfits'; she played an important role in the United Farm Women of Alberta, and their generation of public support for eugenics in Alberta (Christian, 1974: 23).

The Eugenics Board generally fulfilled the requirements of Board membership set out in the *Sexual Sterilization Act*. In other words, two physicians needed to be on the Board, as well as two persons who were not medical practitioners. As we will see in the following chapters, certain "key" individuals were more active than others at the Board meetings. Thus, examining the Board's activities provides us with some interesting insight as to the influence that individuals can play, even in a group situation where policy and procedure are supposedly well laid out by a government Act. As later analyses show, within the organizational structures legislated by the Alberta government, there was in fact much room for particular individuals to maneuver. This freedom to maneuver often resulted in less and less agency on the part of the individual "clients" of the Board. In other words, increasing independence on the part of Board members meant less independence and agency on the part of the feebleminded. We see how these interactions play out in Chapter Six.

Conclusion

This chapter had as its goal the provision of some of the historical and background material that essentially "set the stage" for what was to come in Alberta in terms of the eugenics movement and the activities of the Eugenics Board. We saw evidence that international scientific and philosophical beliefs that, because of the activities of particular individuals and interest groups in Canada, found a receptive home in Alberta. We then looked at what was going on at different 'levels' in society – from the social structural or cultural level, to the political/institutional, and finally the individual level. We also got a taste of the ways in which the various individuals and groups promoted the ideal of a eugenics program. We saw, too, hints of why these groups and individuals seemed to take an interest in the eugenics cause. Some of them were personally troubled by increasing rates of immigration, and what they perceived as 'poor stock' entering the country. Other groups were concerned with the declining levels of intelligence in schools, which seemed to be tied to illegitimacy and delinquency, as illustrated by Hincks' surveys in the prairies. Still others were concerned with, among other things, crime and the tax burden of institutionalizing the 'inferior' stock. Finally we also saw some examples of how these fears were built on through the use of linguistic and rhetorical techniques.

Chapter 3: Theory and Literature Review

The Social Constructionist Perspective

Working from a social constructionist perspective means that one should "focus on the processes by which people designate some social conditions as social problems" (Best, 1995: 6). "Our sense of what is or is not a social problem is a product, something that has been produced or constructed through social activities" (Best, 1995: 6). These social activities may include such things as demonstrations, legislative bills, published stories, or group meetings. It does not matter whether the conditions that are the object of concern actually exist. What does matter, and what is taken as problematic and something to be analyzed, is the fact that people make claims about these conditions (Best, 1995). Essentially, from a constructionist position, and from the position taken in this project, social problems are claimsmaking activities. "Our views of social problems are constructions" (Best, 1995: 7).

A contextual constructionist takes into account other factors that influence the claimsmaking enterprise. In other words, contextual constructionism seeks to locate claimsmaking within its context. "Claims emerge at particular historical moments in particular societies; they are made by particular claimsmakers, who address particular audiences" (Best, 1995: 345). As Rafter states, "the contextualist's position on conditions gives sociologists more latitude to move beyond claims-makers' perceptual frameworks to identify factors (such as class and gender interests) to which claimants may have been oblivious but which nonetheless shaped their claims" (1992:19).

The approach used in this study is both historical and sociological in nature and draws on social constructionism in its analysis of this particular 'social problem' – the problem of "feeblemindedness" and eugenics. As Rafter states:

> while historians have been investigating eugenics since the 1960s, sociologists have given it little attention, even though it offers rich materials for those interested in social movements, coercive institutions, policy formations, class relationships, and social problem construction" (1992: 17).

When studying a 'social problem' such as the Eugenics movement in Alberta, one might ask who played a key role in constructing the 'problem' of mental defectives and the mentally ill? Who felt the necessity to implement the Sexual Sterilization Act of 1928, which allowed for the sterilization of hundreds of institutionalized individuals? Who was able to take these claims and rally support within the province and within the government? What sorts of responses were received for these claims? Why was there no outcry against the claims, and if there was, why was it not as influential as the cry for sterilization? Why did claimsmaking in Alberta result in The Sexual Sterilization Act, while similar claimsmaking activities did not have the same result in, for example, Ontario? These are questions that are explored below.

Social Problems and the Social Construction of Social Problems

It has been argued that sociologists should study the *process* by which a group arrives at a definition of a social problem (Blumer, 1971; Kitsuse and Spector, 1973). The emphasis should be on the subjective component of social problems. A sociology of social problems should focus on the activities of groups actively involved in defining the problem; it should focus on claim-making and responding activities (Kitsuse and Spector, 1973). Since claimsmaking can include a variety of activities ranging from writing letters to the editor to lobbying political parties, studying the causes of social problems is to account for the ways in which such activities are initiated and sustained (Schneider, 1985). What is crucial to an understanding of social problems and claimsmaking behaviour is an awareness and analysis of the social process of definition. To aid in understanding the process of social problems formation, Spector and Kitsuse (1973) propose a four-stage natural history model.

The first stage looks at the condition that a group perceives as problematic and its collective attempts to remedy the condition (Spector and Kitsuse, 1973). At this stage the important issues include the ways in which claims are formed and presented, the power of the group(s) involved, the strategies used by the groups to have their views heard and publicized, and the creation of a public controversy (Schneider, 1985: 212). The second stage begins when the claims made by the groups are recognized by official and influential institutions (Spector and Kitsuse, 1973). After this point in the natural history model, an institution is involved. "Social problems thus become routinized in an organization charged with doing something about the putative conditions" (Schneider, 1985: 212).

Stage three begins when participants claim the official, institutional response to the social problem is inadequate or problematic. In other words, official acceptance of the problem by the institution creates a possible basis for a new definition of the problematic condition based on the official response (Schneider, 1985). Stage four is "marked by claimants' contention that it is no longer possible to 'work within the system' and their attempts to develop alternative institutions" (Schneider, 1985: 212). As sociologists, we should not be concerned with the validity of the claims of participants. Rather, our concern should be with how such definitions are created, documented, and kept alive (Schneider, 1985).

The Eugenics movement in Alberta fits the mold of a social problem warranting analysis from a social constructionist, social problems perspective. But before delving deeper into this particular example, some other examples of research in the area of social problems construction are reviewed.

Examples of Social Constructionist Studies

Loseke uses a social constructionist perspective in analyzing how claims can be read as offering justifications for a policy called "community mental health" (1995). She traces the way in which in the United States perceptions of the necessity for mentally ill people to be involuntarily confined changed, resulting in changes in policy. She states that "regardless of power, motives, or material conditions, social policies must be *morally* justified and this can be accomplished by constructing images of types of persons in types of conditions" (1995: 261).

Loseke illustrates how claims constructing the homeless mentally ill as rational actors reacting as a 'normal' person would to oppressive social conditions promoted their right to remain on the streets. Other constructions created the image of the homeless mentally ill as "mad" and therefore in need of being sent to mental hospitals. The media played a significant role in the creation of these images of the mentally ill.

In each case, the constructions created very practical changes in policy and in the social order.

Other examples of social construction studies and literature include Stephen Pfohl's (1977) analysis of child abuse. Pfohl's analysis contextualizes the creation of a new diagnosis, "Battered Child Syndrome", in the opportunity structure for radiologists to promote and enhance their careers (Schneider, 1985). Pediatric radiologists, as professional moral entrepreneurs, identified the new condition, and so carved a new niche for themselves in the medical system (1977). Llewellyn's analysis of the social construction of epilepsy in medical texts (1998) also illustrates that "epilepsy is not a self-evident fact of nature but a social construction reflecting ever changing ideas about particular kinds of phenomena" (50). Instead of a linear progression in medical knowledge in understanding and diagnosing 'epilepsy', a hidden curriculum of eugenics seems to have influenced the definition and diagnosis of people exhibiting particular symptoms (1998).

Another constructionist study dealing with children is Best's work on the construction of the "missing children" problem. Specifically, he looks at the rhetoric used in claimsmaking regarding this social problem. Best argues that claims and claimsmaking activities are tied closely to the social and historical context. He points out that the "missing children problem" appeared during the 1980s - a time period where an awareness of the victimization of children was becoming more pronounced. Best argues that the links between rhetoric and cultural context deserve our systematic attention (1987). The rhetorical choices made by claimsmakers inevitably affect the success or failure of their specific claims (1987: 118).

In Kay Anderson's *Vancouver's Chinatown,* we are introduced to the social construction of a race in Canada. She illustrates through the use of historical, political, economic, spatial and temporal analysis, the way in which Chinese people in Western Canada, and particularly in Vancouver, were ascribed an identity that continues to this day. Essentially, Anderson traces "the construction of knowledge about the Chinese, demonstrating how it informed government practices and conditioned the territorial arrangements through which racial concepts were inscribed and reproduced" (1991:

246). She examines in detail the contextualized process through which 'race' was constituted as fact throughout the history of the Chinese people in British Columbia (246).

These social constructionist studies reveal two key features characteristic of this type of research. First they illustrate the ways in which perceptions of problems change with time. Prior to the activities of the pediatric radiologists in the late 1960s, the "problem" of child abuse did not receive the same type of attention that it did after that point. In Anderson's study we are directed to the changing construction of the Chinese "race" over time, and how the changes were directly related to the changing historical context. Second, these studies illustrate the importance of claimsmakers to the social construction process. In each case, key powerful groups are shown to influence the perception of the "problem" and the way the "problem" is constructed. These are two themes that we see surface in relation to the social construction of the "feebleminded" as well.

The Medicalization of Deviance

Conrad and Schneider (1980) focus on deviance as an attributed designation as well as on the historical, social, and cultural processes whereby individuals, behaviour, attitudes, and activities come to be defined as deviant (17). They also point out that "the power to so define and construct reality is linked intimately to the structure of power in a society at a given historical period" (Conrad and Schneider, 1980: 17). Analyzing the construction of deviance from a labeling-interactionist perspective, these authors provide interesting insights into the process by which deviance status changes from badness to sickness. "...the labeling-interactionist perspective views deviance as relative to time, place, and audience and as an attribute that is conferred on people by others" (Conrad and Schneider, 1980: 18).

Conrad and Schneider emphasize the construction of deviant status as both a result of a historical social construction of reality, and also as a result of the activities of groups of people with special interests. This perspective is particularly relevant to this study in that it provides us with a way of looking at the way in which certain behaviours became defined as deviant. It also helps to explain why it was that a medical solution to the 'problem' of feeblemindedness was offered. The solution was sterilization. Throughout their book Conrad and Schneider point to the ways in which behaviours considered deviant are defined as medical problems so that medical 'solutions' can be offered to help deal with them. The process of definition and the ascension of medical solutions are both highly political processes. For example, the authors illustrate the role that physicians played in promoting medical solutions to deviance "problems"; they had a vested interest in expanding their roles in society, their influence as experts, and their control of social control institutions. Others also play an active role in creating these definitions of behaviours. "Morality becomes the product of certain people making claims based on their own particular interests, values, and views of the world" (Conrad and Schneider, 1980: 2).

As we see in the case of Alberta eugenics, various individuals and interest groups, as well as physicians, were able, because of power differentials, to assign deviant labels to the mentally ill and the 'mentally defective'. But their influence did not stop here. Because of the growing influence of medicine and the medical model of deviance, they were also able to offer 'solutions' to the problems of promiscuity, criminal behaviours, and drunkenness, among others. This solution was medical in nature. The deviant was no longer a criminal needing punishment, as much as s/he was a sick, "backward" individual in need of surgery and medical help and control. As Conrad and Schneider state, "thus by medical social control we mean the ways in which medicine functions (wittingly or unwittingly) to secure adherence to social norms - specifically, by using medical means to minimize, eliminate, or normalize deviant behaviour" (1980: 242). Sterilization appears to be one way in which some deviant behaviours were eliminated.

How is This Approach Different from Other Approaches?

The story of the Eugenics movement in Alberta is a story with many perspectives. There are different levels of analysis involved – starting with the broadest level, the social structural level, all the way down to the interactionist level – what was going on between individuals. As we see below in the literature review of studies conducted on the Alberta eugenics movement, different researchers have focussed on different aspects of the story. I have chosen the social constructionist perspective for various reasons. Before exploring some of the ways in which this approach is different from others, I would first like to point out the similarities between this school of thought and others informed by similar philosophical underpinnings.

Constructivist and interpretivist approaches are similar in that both are descriptors "for a loosely coupled family of methodological and philosophical persuasions…these terms are best regarded as sensitizing concepts" (Schwandt, 1994: 118). The approaches suggest directions along which to look, rather than "provide descriptions of what to see" (118). Both approaches also share a concern for the emic point of view, for understanding the meaning, for "verstehen"[1]. The goal is to understand "the complex world of lived experience from the point of view of those who live it" (118). Interpretation is key to these approaches.

> The constructivist or interpretivist believes that to understand this world of meaning one must interpret it. The inquirer must elucidate the process of meaning construction and clarify what and how meanings are embodied in the language and actions of social actors. To prepare an interpretation is itself to construct a reading of these meanings; it is to offer the inquirer's construction of the constructions of the actors one studies (118).

Both approaches are concerned with "knowing" more than they are concerned with methods of knowing. In other words, understanding and interpretation can be achieved through a variety of methods. How one decides to conduct one's research is based on the inquirer's purpose, which in turn is shaped by epistemological and methodological commitments (119). Although both perspectives share a common philosophical heritage, distinctions can be made between the two in terms of the following two questions: 1) What is the purpose and aim of human inquiry? 2) How can we know about the world of human action? (118). After comparing the approaches by answering these questions, I illustrate how it is that this study is more constructivist than interpretivist.

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[1] According to Max Weber, who is largely responsible for introducing the concept to sociology, verstehen consists of placing oneself in the position of other people to see what meaning they give to their actions, what their purposes are, or what ends they believe are served by their actions (Nicholas Abercrombie, Stephen Hill and Bryan S. Turner. *The Penguin Dictionary of Sociology, 1984).*

Answering the first question means addressing ontological and epistemological issues. This relates to questions regarding "reality" – what is there that can be known? And what is the relationship between knower and what can be known? (Guba and Lincoln, 1994: 108). Interpretivists, "owing in part to unresolved tensions between their rational and romantic roots…wrestle with maintaining the opposition of subjectivity and objectivity, engagement and objectification" (Schwandt, 1994: 119). They see their role as researchers as that of an objective observer attempting to place himself or herself in the shoes of the subject to gain understanding. As a result, the problem that emerges is "the paradox of how to develop an objective interpretive science of subjective human experience" (119).

As an example of the interpretivist, Schwandt discusses symbolic interactionism. He points out that these theorists "evince a profound respect for the empirical world" (1994: 124).

> The symbolic interactionist holds that a necessary (although not sufficient) condition for the study of social interaction is careful attention to the overt behaviours and behaviour settings of actors and their interaction (124).

In others words, ontologically, symbolic interactionists do allow for an empirical reality 'out there' to be studied. Epistemologically, the goal is to see the world as seen by the actor, observe what the actor takes into account, and observe how he interprets what is taken into account. In making these observations and descriptions, the researcher is one step closer to formulating an interpretation of what actors are doing (124). How can we know about the world of human action? By observing and interpreting actors' behaviours as we try to see the situation as seen by the actor. Symbolic interactionists move between the world of theory and the world of the actors; in seeking explanations of the world "they view explanatory theory as interpretive, grounded, and hovering low over the data" (124).

Constructivism in the social sciences is, in comparison to interpretivism, a relatively new perspective. The two perspectives share similar concerns, particularly the focus on the world of experience as it is lived by social actors. Yet, as Schwandt points out, there are particular foils which set the approaches apart: notions of objectivism, empirical realism, objective truth, and essentialism (1994: 125). Ontologically and epistemologically, the two are different. We saw above that interpretivist approaches allow for some degree of objective truth that can be discovered. On the other hand,

> constructivists are deeply committed to the contrary view that what we take to be objective knowledge and truth is a result of perspective. Knowledge and truth are created, not discovered by mind....reality is expressible in a variety of symbol and language systems...it is stretched and shaped to fit purposeful acts of intentional human agents...there is no unique 'real world' that preexists and is independent of human mental activity and human symbolic language (125).

The constructivist belief is that humans do not discover knowledge as much as they construct it. It is important to point out that while knowledge, concepts, and ideas are constructed rather than discovered, this perspective does not have to be antirealist. Such inventions or constructions are invented but they correspond to something in the real world (Schwandt, 1994: 126).

For social constructionists, the ontological question is answered as follows: "the world that people create in the process of social exchange is a reality *sui generis*" (Schwandt, 1994: 127). How does the researcher access this reality? "The terms by which the world is understood are social artifacts, products of historically situated interchanges among people" (127). Different from interpretivism is the view that social constructions reside in the minds of individuals. "They do not exist outside of the persons who create and hold them; they are not part of some 'objective' world that exists apart from their constructors" (Schwandt, 1994: 128).

The purpose of inquiry for constructivists is "*understanding* and *reconstruction* of the constructions that people (including the inquirer) initially hold" (Guba and Lincoln, 1994: 113). Additionally, the constructivist paradigm holds activism and advocacy as key concepts and goals. This is another area where interpretivists and constructivists differ. Interpretivists typically seek to distance themselves as inquirers; for example the goal in traditional ethnography is to document the lives of the subjects – to discipline his or her subjectivity and exhibit a disinterested attitude. For constructivists, there is a critical element to their work and constructions;

incorporating the values of altruism and empowerment are central to their work (Schwandt, 1994: 131; Guba and Lincoln, 1994: 115). As Guba and Lincoln state "the inquirer's voice is that of the "passionate participant" actively engaged in facilitating the "multivoice" reconstruction of his or her own construction as well as those of all other participants" (1994: 115).

The present study is most accurately placed in the constructivist camp. Because of the nature of the research endeavor, it makes most sense to treat the activities of the Eugenics Board and its affiliated institutions as examples of the construction of a social problem. The concern of the study is to analyze how the groups involved constructed the problem of feeblemindedness, and how they constructed solutions to the problem. As such, the 'reality' is a constructed one, based on the activities of participants. The idea of an objective truth which must be documented does not adequately represent the emphasis on process and human agency that essentially created a problem and then created a response to the problem. Approaching the research questions from any other perspective would not provide the rich insights that a constructionist perspective can offer. True, interpretivism can also provide detail and insight, but the detail is that of the "objective" observer who has distanced herself from the subjects. Additionally, the constructionist perspective allows the researcher to incorporate a critical response to the construction process at the time, and allows for the inclusion of the voice of the feebleminded, which again, is not the focus of interpretivism. As both a theoretical and methodological approach, social constructionism allows for a grounded approach to understanding and reconstructing this social problem.

Foucault

It is difficult to discuss issues relating to power, knowledge and the social construction of problems without drawing on the work of Foucault. While I am not proposing to use his ideas as a basis for the entire study, the relevance of his work to the present topic is obvious. For this reason, a brief presentation of the applicability of his theorizing is described here.

Knowledge is power. In making this point, Foucault is a social constructionist of the truest sort, for he doubts that we have any knowledge of absolute truth. Our perceptions of truth change with the changing characteristics of those who have power. Knowledge is what a group of people decides is true. People with knowledge – often a minority, since knowledge is a privileged commodity – can impose their views on the majority. In so doing, they are constructing the truth – their truth. Because of their knowledge and power, their truth becomes THE truth and so becomes the defining criteria of humanity. If experts say something is so, then it must be so. If they say that people with low IQs must be locked up and then sterilized, that is the way things should be. Who are we, those without 'expert' knowledge and power, to question their definition of what is right and good?

Furthermore, this knowledge/power monopoly by the minority is facilitated by the use of language. In describing a person as "feebleminded" or "mental defective" the experts are also defining that person. They are defining him or her as an "inferior" person, one who needs to be controlled and "taken care of". Language describes but it also defines. In defining it aids in the control of certain segments of the population. Defining behaviour as dangerous allows the "definers" to regulate and control that behaviour. In addition, describing and defining certain groups as abnormal has the effect of also defining for society what is normal. The abnormal (e.g., mentally ill, feebleminded) are locked up, thus reinforcing to the rest of society that to be normal is not to be mentally defective and therefore not to be locked up. In other words, by studying abnormality - by making it a topic of discussion and debate for and by experts – power relations are established in a society.

The logical conclusion of this process is that the "normal" will have power (knowledge) and the "abnormal" will not. The "normal" psychiatrist has power over the "abnormal" mentally ill person/madman. The "normal" physician has power over the "abnormal" patient. The "normal" criminologist has power over the "abnormal" criminal. The "normal" Eugenics Board member has power over the "abnormal" feebleminded person.

As a social constructionst, Foucault illustrates how definitions of madness, illness, criminality and perverted sexuality vary significantly over time. He demonstrates the ways in which different groups of people gained/created knowledge and then used their power to change the definition of what was normal and abnormal over the history of civilization. In the past, madmen, the sick, and criminals, for example, were not excluded from society – they were not locked away in institutions and prisons. As such, Foucault's work helps us understand what occurred in Alberta in the early 1900s. The definition of abnormal behaviour was changed and as a result the response to such abnormal people also changed. As we see in more detail below, this resulted from the changing knowledge and power on the part of a minority of people – the mental health experts.

The "doctor" is another actor that Foucault examines in detail. Over time, madness is defined as the fault of the individual. Initially, the "mad" were victims of an economic problem – they were unemployed and impoverished people with whom society had to "do something". Eventually though, they were defined as being a moral problem. Not only were they unemployed but somehow they also became evil - evil and dangerous. This new system of morality was very much connected to the newly dominant middle class. It was members of the middle class who became the knowledgeable experts. The danger of madness was defined as coming from the lower class who "chose" not to conform to the middle class standard.

The great moral authority was the Doctor – the ultimate expert. The doctor was the ultimate definer of sickness (immorality) and the ultimate truth-seeker and knower. In *The Birth of the Clinic*, Foucault describes the way in which the patient began to be seen as a "thing to be talked about" – an object. This work is relevant to the present study because of the description of "The Gaze" within an institution. The Gaze refers to the all-seeing nature of the doctor's perception; the doctor sees all and knows all. Nothing is unknown to this expert. In particular nothing about the patient is not seen. The patient is under the watchful, all-knowing gaze of the medical professional. Foucault talks about the purity of the Gaze and how this gaze is essentially pure language. In other words, the doctor's expert perception is translated into a language that defines the patient in a particular way. Since the doctor is an expert, the language he uses is perceived as being objective, scientific, and so truthful language. It is unquestionably correct. Again, the power of definition comes down to language and the all-seeing nature of medical professionals. In the case of the present study, it is not difficult to see how the Eugenics Board and the institutional staff – the medical experts/professionals – came to have the power to define and construct certain individuals as problematic and as needing surgery.

In *Discipline and Punish*, we are presented with more evidence of the power of discourse. Moreover, Foucault demonstrates how the careful control of every aspect of a life can represent a more complete exercise of power than the massive display of a death. Specifically, he provides examples of how people are regulated and controlled by institutions and the State in terms of their bodies, and in subtle ways. No longer are public executions necessary to exert control. All that is needed is the threat of institutionalization, and possibly even the threat of sterilization, to keep people under control.

To summarize, from Foucault's work we get a detailed description and analysis of the power of knowledge and language. We also see how it is that over the history of humankind, discourse has defined what is right and wrong, what is good and sinful, and how this has been translated into what is normal and what is pathological. This is precisely what was occurring in Alberta during the time of the eugenics movement.

Why then is the present study not a "Foucauldian analysis"? As mentioned above, Foucault was the ultimate social constructionist. However, he also modified the approach in his own signature way – he focuses on power and knowledge and incorporates specific concepts to tell his constructionist story. While many of his concepts are applicable here, again, the goal of the present study is to keep the analysis broad in scope. The objective is to incorporate various approaches in trying to understand this social problem. Perhaps the "Gaze" of the Eugenics Board had characteristics that made it different in nature from the Gaze discussed by Foucault. Perhaps not. But I would like to have the freedom to make that call. And narrowly labeling the project a Foucauldian analysis might circumscribe that freedom. As

Schwandt argues, in terms of nonfoundationalist antiessentialist thinking, we stand at a fork in the road. One is the path discussed above – the path of social constructionist research which offer us a modicum of "liberal social hope" (1994: 131). The other is the path of Foucault, "with his despair over the prison house of language" (131). I choose to agree with Schwandt who concludes that he can "find little comfort in a form of interpretivism that degenerates into nihilism, where we do nothing but engage in endless parasitical deconstruction and deny the existence of social order and our very selves" (131-132).

Along with the other contributions he does make, Foucault points out the importance of the medical professions to this type of analysis of social control. It is to a discussion of the 'professions' that we now turn.

The Role of Professions

> Medicine is a moral enterprise like law and religion, seeking to uncover and control things that it considers undesirable (Freidson, 1972: 208).

A discussion of social control and the medicalization of deviance would not be complete without considering the role of the "helping professions" in the eugenics phenomenon. As we saw in the previous chapter, the medical profession, psychiatry, and social work were all gaining status and influence during the early part of the 20th century. This coincides with the development of eugenics theory and the eugenics movement. How does the professionalization of these occupations contribute to an understanding of the social problem of feeblemindedness? To fully understand the complexities of this component of the story, we must begin with a brief description of the push for professional status on the part of the occupations involved.

According to Ritzer and Walczak (1986), historical location is very important to an understanding of professionalization of medical occupations. The early 20th century saw the advancement of medical knowledge and techniques, and science in general. But at the same time, the medical profession itself was not a secure profession. With developments in research and knowledge, the timing was right for medical practitioners, psychologists, social workers and teachers to strive for a more respectable status in society. As McLaren states, "many psychologists, social workers and teachers would also be ultimately drawn to eugenics, in part because by embracing what they took to be a scientific approach to social problems they could enhance their professional standing" (1990: 49-50). The drive for professional status is in large part based on the argument that the 'profession' in question has access to and controls 'expert knowledge' not available to the average person (Ritzer and Walczak, 1986; Blishen, 1969; Freidson, 1972). Part of becoming a profession involves an effort to "constitute and control a market for their expertise" (Ritzer and Walczak, 1986: 81). In all likelihood, the claim to genetic and eugenic expertise played a role in the professionalization of psychiatric and psychological professions in Canada in the early 20th century. As McLaren states:

> through its activities the CNCMH served as a launching pad for both the psychiatric and psychology professions in Canada. Each won increased social status by demonstrating to the public through the various investigative activities of the CNCMH the social importance of their respective sciences…(1990:111)

Support for the movement was widespread within the medical profession; doctors formed the single largest group within the Eugenics Society of Canada (McLaren, 1990). At a time when the helping 'occupations' were looking to 'professional' status it makes sense that they would make a claim to expertise in such an important area. These "potential professions" were claimsmakers in their own right.

In addition to such a monopoly over knowledge and expertise, the 'profession' as a group of 'insiders' develops certain norms that dictate the way business is conducted. There are several such norms for behaviour, but for the purpose of this discussion only a few are analyzed in detail. In addition to the "general, systematic knowledge" only available to members who have spent years studying and being trained, there is a "norm of autonomy" that is critical to the status of 'profession' (Ritzer and Walczak, 1986; Blishen, 1969; Freidson, 1972). This norm insulates professionals primarily from external control and criticism, but also, as Freidson explores in some detail, from fellow professionals (1972). A large part of the respect and independence accorded professionals stems from the layperson's trust in that profession to put the interests of society – of the collectivity - over self- interest

(Freidson, 1972). To be a professional is to be at some level humanitarian and giving. Since purely financial return cannot compensate the individual professional for years of training and sacrifice, it follows that one reason for entering the profession is to 'give back to society', to do good for others (Blishen, 1969). Because of this, it is assumed that autonomy on the part of the professions is acceptable and desirable. Professions, as self-monitoring groups, will undoubtedly act in the best interest of their clients. This is the norm of altruism, their "supposed greater interest in symbolic rather than economic rewards"which, according to these authors, is a myth (Ritzer and Walczak, 1986: 74).

Part of the mystique surrounding professions, and medical professions in particular (included here are medical and psychological professions), is the indeterminacy and uncertainty cultivated by these professions (Ritzer and Walczak, 1986). A source of power for the professions is this indetermination; their tasks cannot be routinized and made public to the masses. Rather, it takes a specialist, a professional to understand the situation, assess it appropriately, and make the correct judgement regarding treatment. This is compounded by the "norm of authority over clients". Many patients, blinded by the uncertainty of their condition, concede power and authority to the professional (Ritzer and Walczak, 1986: 75). Indeterminacy and uncertainty likely figured prominently in the rise of the helping professions during the eugenics movement. Genetic disorders. Hereditary afflictions. Psychological problems. Feeblemindedness. These are all conditions plagued with indeterminacy and uncertainty. They deal with the human mind, human emotions and human conditions, which are all very mysterious and complicated to the layperson. Psychologists with their batteries of tests and doctors with their methods of diagnosis offered the answer to the unknown nature of such afflictions. They provided some certainty.

Power does figure prominently in discussions regarding medical (and other) professions, Once recognized as a profession, the group itself is relatively insulated from outside influence; the 'norms' that characterize the profession in theory become reified by public and legal acceptance. There are many behind-the-scenes factors that come into play which ultimately aid in the achievement of this final result. Recruitment to the medical profession occurs primarily among the higher social classes. In other words, fathers tend to recruit sons into the 'business'. This is important to the professions – it is beneficial to recruit from groups whose beliefs, values and pre-conditioning are conducive to acceptance into the professional group (Blishen, 1969; Freidson, 1972). It is necessary to keep the group open to 'insiders' and closed to 'outsiders'.

Power also figures into the equation in terms of the connections between professions and other dominant elites. As Freidson points out "the success of the professions is primarily in the hands of society's dominant elites" (from Ritzer and Walczak, 1986: 87). The 'would-be' professions must endeavor to convince the elites of their worth. Because these elites have the power to deny the claims of the professions, the latter "must continue to convince the elites of its worthiness…thus the professions are viewed as almost helpless protectorates of these societal elites...they are allowed to exercise power within their domain, but only at the behest of the elites" (Ritzer and Walczak, 1986: 88). Does this imply that the Eugenics Board and its affiliate doctors and Superintendents were merely pawns of the Government of Alberta? It is more complicated than that. As Freidson states, "the state uniformly leaves in the hands of the profession control over the technical side of its work. What varies as relations with the state varies is control over the social and economic organization of work" (1972: 25). Perhaps the medical and psychological professions made claims concerning the problem of feeblemindedness, the government made decisions regarding the social, economic and legal organization of the work of addressing the problem, and the Board with its affiliate professions addressed the technical side of the solution.

At any rate, the profession's monopoly is the ultimate control of the content of its work. According to Freidson, "medicine is engaged in the creation of illness as a social state which a human being may assume" (1972: 205). He argues that the physician/psychiatrist is a moral entrepreneur and plays a crucial role in the social construction of illness. In this sense, the right to create illness is an official social role for the medical professions. According to Freidson, the evaluation of what is normal, proper or desirable is as inherent in the notion of illness as it is in notions of morality. He is essentially arguing that the medicalization of deviance is one of the ways in which the medical profession can establish its credibility, make work for itself, and establish its credibility. "When the physician claims alcoholism is a disease, he is as much a moral entrepreneur as a fundamentalist who claims it is a sin" (1972, 253). Furthermore, scientific medicine is "irrelevant for the task of explaining the 'illness behaviour' of the sufferer and for the task of explaining the 'diagnosis behaviour' of the man who treats him" (1972: 211). While the "sickness" may or may not be biologically "real", the sick role is always socially "real" (212). This claim to be experts in the diagnosis of what are often 'social afflictions' is compounded by one of the guiding rules of the medical profession, which is to "overdiagnose" – it is better to be safe by diagnosing illness rather than health (255).

How does this relate to Eugenics? Most obvious are the connections between the political elites and the medical profession, the need for the medical professionals to maintain their status by showing the political elites that numbers of "feebleminded" were increasing and needed treatment, treatment and diagnosis which could only be provided by the professions in question. Further to this, we have an interesting approach to the actual conditions that were being 'diagnosed'. Were they based on 'biology'? Were they 'socially created' by a group working to establish and maintain credibility in the eyes of the public and the government? According to medical experts in the 1930s in Canada, social problems were medical problems. A leading psychiatrist during this time argued that crime was an illness. "The average criminal…being also a mental invalid, gravitates most naturally into a life of habitual crime. It is not only somewhat absurd, but often specifically dangerous to allow such individuals to be at large at all (McLaren, 1990: 119). As agents for social control, medical professionals have official state mandate to apply their knowledge and values to the world about them (Freidson, 1972: 303). As McLaren states: "Deviant behaviour – as defined by white, male, middle-class, Protestant professionals – and not any proof of genetic failure was what led to sterilizations" (1990: 168).

Freidson argues that while professionals may indeed be arbiters of 'expert' knowledge, the danger occurs when this self-sustaining, autonomous group, drawn from the same social class, and immune from external (and internal control) are allowed to influence social policy and label groups as deviant. His concern is that expertise is in danger of being used as a mask for privilege and power rather than as it claims, as a mode of advancing the public interest (1972: 337). Autonomy in developing knowledge is fine for the professions, but autonomy in applying that knowledge is not. The doctors affiliated with the Eugenics Board in Alberta are an example. The profession answers to no one but itself – which we see below is what occurred with the Board and its doctors. Furthermore, as the profession (or in this case the Board and its doctors) develops its narrow and distorted perspective, it cannot be reasonably expected to assume the perspective of its clientele. "If it cannot assume the perspective of its clientele, how can it pretend to serve it well?" asks Freidson (1972: 370). "Its very autonomy had led to insularity and a mistaken arrogance about its mission in the world" (370).

As we will see below, the social construction of feeblemindedness at the hands of the "eugenics professions" illustrates what Freidson describes as the result of unregulated autonomy of medical professionals. "When he preempts the authority to direct, even constrain men's decisions on the basis of his own values, the professional is no longer an expert but rather a member of a new privileged class disguised as expert" (1972: 382). The "helping professions" were striving to achieve legitimacy and power at precisely the time when the eugenics movement in Alberta was in its formative stages. It is likely that the professions saw the eugenics movement as a means to an end and therefore put much energy and support into the movement.

Framework for Studying Deviance and Social Control

Using the example of the Alberta Eugenics Board from 1928 to 1972, I analyze the claimsmaking activities, from a contextual constructionist perspective, that occurred at the social structural, political/institutional and interactional levels, and the implications this behaviour had for government policies and activities. The social structural level refers to the broad historical context described in a previous chapter.

The political/institutional level refers to what was occurring within and among interest groups, institutions, and government bodies at the time. Finally, the interactionist or individual level refers to the types of people involved and the micro-level communications and activities occurring at the time. My goal is to use the three levels of analysis to explain how and why it was that hundreds of people were robbed of their reproductive capacity during this time in Alberta history. How were they defined as deviant and how did they become objects of control by the social agencies involved? But before presenting the framework within which this case study is situated, I first provide further background on the eugenics movement, other studies that have been conducted on the movement, and finally the case of the Alberta eugenics movement.

The Case of Eugenics

The eugenics movement, its inception, development, and fall from grace, and its ties to Nazi Germany, the segregation movement, genetics, and various other movements and trends in philosophy and science, have been researched a great deal over the decades (Brantlinger, 1995; Carey, 1998; Dorr, 1999; Gosney and Popenoe, 1929; Haller, 1963; Hasian, 1996; Ingle, 1973; Kevles, 1997; Kuhl, 1994; Ladd-Taylor, 1997; Laughlin, 1922; Paul, 1995; Proctor, 1988; Rafter, 1992; Reilly, 1991; Stern, 1999; Robb, 1998; Usborne, 1997). Starting with the studies on the Jukes (Dugdale, 1877) and the Kallikaks (Goddard, 1912)[2], early eugenics research addressed many issues. Studies documented eugenics as a philosophy, a science, and a movement. Researchers analyzed the advisability and efficiency of segregation versus sterilization, of institutionalization versus parole of feeble-minded people, of the economic benefits of work farms as opposed to asylums.

More recently, critical researchers have analyzed the connection between eugenics and gender, race, class, and intelligence testing. Others have analyzed the institutions themselves, the agendas and activities of the superintendents of these institutions, and the ways that these institutions played into and were influenced by the broader eugenics movement. The politics of eugenics - the influence of legislation and the activities of interest groups in influencing the actions of social control agencies - is also another area of research.

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[2] Richard Dugdale's *"The Jukes": A Study in Crime, Pauperism, Disease and Heredity* (1877) and Henry Goddard's *The Kallikak Family: A Study in the Heredity of Feeble-Mindedness* (1912) both chronicle the histories of two families descended from "defective" ancestors. These studies were cited extensively and were considered authoritative works on the topic of eugenics.

This section of the chapter is a brief overview of some of the recent critical literature dealing with these issues. The presentation of these studies has been organized according to level of analysis, which corresponds to the way in which the present study is organized. In other words, I start with a study that focuses on the socio-cultural context of eugenics in the United States. As well, this study describes and analyzes the roles of interest groups and individuals involved in the eugenics campaign in the United States.

Eugenics and the Socio-Cultural Context

Rafter (1992) writes about the socio-cultural context of the first U.S. Eugenics Campaign using both historical and sociological approaches. She uses a contextual constructionist perspective and draws on social problems theory in her analysis. The first campaign which began in 1870, was instrumental in officially defining fertile, feeble-minded, female paupers as dysgenic and constituted a "very early attempt to criminalize not an action, but the body itself (i.e., the condition of being both female and a carrier of bad heredity)" (Rafter, 1992: 17). For this author, the campaign itself is what is problematic, and not so much the actual results of the campaign.

Rafter outlines the activities of one woman in particular who played a significant role in influencing the establishment of prophylactic institutions for the care of feebleminded women. Such institutions were to protect their patients from the risk of pregnancy during their childbearing years. Josephine Shaw Lowell, acting in a social context involving alarm about spreading poverty, a town that wanted responsibility for a lucrative asylum, dramatically changing women's roles, a growing feminist movement, a personal history that influenced her ambition and skill, and a societal atmosphere conducive to experimentation in social control, was influential in the eugenics campaign. She concludes with the following, which illustrates this point well:

> In the case of Lowell's campaign, sociology focuses us on eugenics as itself a social problems discourse, a broad-scale effort to redefine poverty, mental retardation, and criminality and to find new ways to

> control the dependent, defective, and delinquent classes. Constructionism provides tools for discussing eugenicists' claims and strategies, and it pushes us to specify the groups that helped implement eugenic solutions and the nature of their support. Sociological analysis of this campaign's rhetoric shows why a mixture of protectionism and coercion came to characterize the negative eugenic solution of prophylactic institutionalization, and it helps locate eugenics in the history of gender, organizations, and social structural change (Rafter, 1992: 29).

In her article, entitled "Arm in Arm: Gender, Eugenics, and Virginia's Racial Integrity Acts of the 1920s", Dorr illustrates the way eugenicists "manipulated ideas about race, class and gender to create a social crisis" (1999: 143). She is essentially writing about the social construction of the problem of certain marginalized populations (white women and black men). The eugenicists and other claimsmakers of the time used sexual and racial stereotypes to "create" the problem of racial purity and then presented eugenic policies as the only viable solution to the problem. A significant contributing factor to this "problem" was women's growing independence and new social behaviour during the 1920s. Women were increasingly expressing their sexuality, independence and freedoms in public ways and public venues (1999: 147). This encouraged eugenicist and other activists to lobby for legislation that would control their behaviour. The Racial Integrity Act was one expression of these concerns. This Act was a law forbidding a white person to marry anyone of another race. In practice the Act was enforced in relation to white woman/non-white male unions. At any rate, Dorr illustrates the importance of socio-cultural context to the activities of claimsmakers and the passage of restrictive legislation intended to control specific marginalized populations.

Stern, in her article on the emergence of the eugenics movement in Mexico during the 1920s and 1930s, similarly situates the popularity of the movement in the context of social structural change and gender issues (1999). Certain key individuals used the media, wrote articles and books, and lectured to classes of students on the merits of eugenics. Stern looks at issues of motherhood, sexuality and child welfare as part of a broader process of medicalization and state expansion. She situates her discussion in the context of post-revolutionary Mexico, emphasizing the importance that the violence of the revolution, combined with epidemics, poor health care and emigration to the North had for the reconstruction of the country. Part of the reconstruction process was to focus on reproduction and socialization, both of which drew the attention of eugenicists (370). One end result of the expanding welfare state during this time, and the influence of eugenics principles was the restructuring of the family and the nationalization of women. Women, and in particular, 'good women' who were 'good mothers' were a national resource to be used and controlled in an effort to rebuild the country.

Eugenics and Gender

Stern's article focuses on the inextricable link between eugenics and motherhood, sexuality and child welfare in Mexico's eugenics movement. In Mexico, child hygienists and eugenicists were given the task of "rescripting the behaviour of mothers on behalf of the post-revolutionary state" (1999: 375). In introducing the notion of responsible motherhood, these experts placed the responsibility for healthy babies directly on the mothers' shoulders, "whose rearing practices were increasingly monitored and tied to the nation's need to secure a vigorous and healthy descent" (1999: 375). Similar themes emerge from the American and Canadian movements as well, perhaps not as clearly and obviously stated as in Mexico, but the tendency to target certain women was the practice in many cases.

Carey (1998) researches the changing relationship between gender and sterilization programs between 1907- 1950. She illustrates the ways in which it became more acceptable to sterilize women than men. While initially men were sterilized in greater numbers than females, after 1928 women became "the more likely targets, and after this transition occurred, the activity of sterilization programs skyrocketed" (Carey, 1998: 74). It appears from the data that in early programs "women were persecuted for activity within consensual, heterosexual relationships whereas men largely were able to avoid punishment for this level of sexual activity and instead received condemnation for more severe infractions of sexual norms" (Carey, 1998: 75). Specifically, men were sterilized more for inappropriate sexual behaviour within institutions, and to punish severe sexual violations within society (Carey, 1998; Tylor, 1977). "Eugenicists criminalized women's sexual relations and reproduction and used sterilization as a means to regulate their non-criminal sexual relations" (Carey, 1998: 81). Women were essentially being sterilized for behaviour that, in the male segment of the population, was considered normal and healthy.

Carey explores in detail the changing societal context, changing attitudes of superintendents and other officials, and the attribution of sole responsibility for heredity on the shoulders of women in explaining the gender shift in sterilization operations. She reviews the influence of the birth control movement, the introduction of mother's pensions for 'fit' mothers, feminist ideology, changes in law, and the emergence of the welfare state as important factors that helped to bring about the shift in gender emphasis in eugenic practices. They all contributed to "create women as the favored target of sterilization programs" (Carey, 1998: 100).

It appears from the research that women and girls were a favored target of many social movements and campaigns that were tied either directly or indirectly to sexuality. Some of the findings of these studies are discussed because they are relevant to the issues surrounding the problem of the feebleminded. The Progressive Era (early twentieth century) seems to have marked the time during which many of the stereotypes and double standards regarding female sexuality were addressed by government legislation, the active work of reformers, and some members of the public. It was during the Progressive Era that female delinquency came to be widely perceived as a social problem (Schlossman and Wallach, 1993). In particular, the stereotypical assumptions about women – and especially immigrant women – laid the basis for a more punitive treatment of delinquent girls than boys. These authors confirm what Carey and others have pointed out: girls were prosecuted almost exclusively for "immoral" conduct, a broad category which defined all sexual exploration as fundamentally perverse and predictive of future promiscuity and possibly prostitution (Schlossman and Walach, 1993). These views combined with eugenics theory and the pursuit of a more "pure" society resulted in the harsher treatment of female delinquents than male delinquents, despite the fact that the latter were more likely to be charged with actual 'criminal' as opposed to 'immoral' behaviour.

The female delinquent was characterized as a "fallen woman" possessing an "innate moral perversity" for which there was little hope or help. Despite growing government involvement in dealing with such afflicted individuals, the prevailing belief was that such girls were much less malleable than male delinquents. Adolescence for boys was a time of experimentation, from which the young lad could recover and be successfully molded into a law-abiding young man. For girls, adolescence was "seen as a less promising period for reshaping character" (Schlossman and Wallach, 1993: 436). This was compounded by the belief that "girl delinquents, unlike boys, were not at all childlike in their behaviour" (437). As well, it was the girls' mothers who were to blame for their daughters' delinquency. As a result, probation for girls was a less effective, and therefore less used option. So, while boys were put on probation, girls were incarcerated (437). The female delinquent had to be removed from society to protect her from society, but also so society could be protected from her (Schlossman and Wallach, 1993: 438).

Schlossman and Wallach (1993) suggest that the cultural context at the time contributed to the definition and solution of the problem of female juvenile delinquency. The Progressive Era was marked by a sexual revolution (Robb, 1998). It may be that the medical and legal experts were reacting to the new mores by emphasizing the old Victorian order. All that was sexual, and that had previously been a private matter, was now the concern of the public and the government. For example, prostitution, sex education and divorce were all considered public problems to be regulated by law (Kushner, 1993). One approach was to incarcerate what claimsmakers perceived to be sexually precocious young girls.

These delinquent girls were especially problematic for eugenicists, for several reasons. First, delinquent girls appeared at first to test at somewhat lower I.Q. levels than delinquent boys. Second, there was a belief that women bore the primary moral responsibility for determining whether to have children. Third, women were seen to lack the sexual drives of men, so sexually precocious girls were morally and biologically perverse. Since the IQ of delinquent girls was below normal, they could never learn to control their instincts (Schlossman and Walach, 1993: 433).

One group of professionals, psychiatrists, defined such "hypersexual" women as "psychopaths" who "suffered from an inborn condition for which there was no remedy save institutionalization" (Lunbeck, 1993: 464). Medicalization of female immorality as a conduct disorder was an attempt by psychiatrists to "control the discourse concerning women's erotic nature" (Lunbeck, 1993: 466). With the advent of the medical professions, such promiscuous women were no longer "bad" as much as they were sick and in need of help. Again, this discourse is tied to the changing nature of sexual mores of the time. But such constructions were also tied to the concomitant desire for freedom and independence on the part of young women. As Lunbeck states, "implicit in the category of hypersexuality was a concern over female autonomy" (1993: 474). Girls who sought the same freedoms accorded boys were by their very desire delinquent. In an era of scientific and psychiatric development, what earlier had been blamed on defective intelligence was now blamed on a psychopathic personality (1993: 475). The reason for this change? It became obvious from intelligence 'tests' that prostitutes and sexual delinquents scored too high to be feebleminded. Therefore, another construction was needed (1993: 476). The "diagnosis of psychopathic personality satisfied their search for a medical diagnosis for immorality" (1993: 476)

Related to the development of new sexual beliefs in the Progressive Era was the emergence of the birth control movement. For reasons mentioned above (women were believed to control the number of children in a family), this movement was directed primarily at women. However, the birth control movement illustrates the intersection of gender with class in this particular discussion of sexuality and eugenics. Initially, the goal of the movement was to aid in the sexual liberation and freedom from repression of the working class. However, because of its working class focus, the movement was suppressed. When Margaret Sanger, the leader of the movement, changed the rhetoric from that of helping the working class to one of controlling population and reproduction – in other words of limiting the working class threat to society through birth control, the movement gained wider acceptance. Birth control became more accepted (Kushner, 1993: 456).

Finally, institutionalization of unwed mothers and female delinquents requiring sexual reform and domestic training was a recurring theme during the Progressive Era. It was necessary to remove the girls from the streets where the threat of prostitution lurked and where innocent boys might fall prey to their worldly and devious sexual influence (Schlossman and Wallach, 1993; Lunbeck, 1993). Through this time period, though, the nature of institutionalization changed as well. By the 1920s in the United States, the growing authority of medicine removed the care of illegitimate pregnancies from matrons who ran institutions for unwed mothers, and replaced them with the medical domain of the therapeutic state (Brumberg, 1993: 234). "Social workers with psychiatric expertise replaced the evangelically-oriented matron" (Brumberg, 1993: 235). But while constructions of female sexuality and the responses to them changed, what remained consistent throughout was a concern with regulating female sexuality and the expression of that sexuality outside "proper" channels.

Eugenics and Race

Any discussion regarding eugenics is at some level about 'race', since eugenics deals directly with 'race betterment' and "stemming the flood of defective aliens" (McLaren, 1990; 46). Eugenicists were primarily concerned with removing defective genes from the human gene pool. Often 'defectiveness' was linked to race and immigrant status. We saw above the significance of immigration to eugenic discussions in the Canadian context. Immigration issues were also of paramount importance to American discussions on the topic (Paul, 1995). Both countries have a history of tensions over immigration policies, often marked by pushes toward more restrictionist immigration acts (Chapman, 1977; Paul, 1995; McLaren, 1990).

In the United States, Northerners were concerned that immigrants from "undesirable" countries would contribute to racial degeneration; in the South which lacked a large immigrant population, eugenicists concentrated on what was referred to by some as the "Negro problem" (Dorr, 1999: 148-151; Hasian, 1996: 53). American eugenicists advocated four policies of negative eugenics: immigration restriction, racial segregation, restrictive marriage laws and compulsory sterilization (Dorr, 1999: 145). Virginia's Racial Integrity Acts of the 1920s were directly related to concerns about miscegenation. "Virginia broke new ground in racial legislation with this act" (144). As an example of a eugenic policy, the Act reinforced existing racial hierarchies while at the same time legitimizing culturally based social policies in the name of science (145).

As Fong and Johnson (1974) suggest, Galton's definition of eugenics is laden with racist ideas. His definition of eugenics is: "the study of agencies of social control which may improve or impair the racial qualities of future generations either physically or mentally" (1974: 97). Fong and Johnson argue that when Galton used the term "impair" he was referring to people of color and poor whites; when he used the term "improve" he meant upper-class whites (97). As further evidence of the contribution of eugenics to the institutionalization of racism in the United States, these authors analyze the operation of the Human Betterment Foundation. This organization was one of the most powerful eugenics organizations. Based in California, its leaders were influential in both manipulating public sentiment on the issues of race and eugenics, but also in contributing to the institutionalization of racism as a result of its activities. The Human Betterment Foundation made arguments such as the following:

> "America's Burden" was comprised of several component features: overwhelming economic cost to provide and maintain public institutions to care for the unfit; the constant threat of racial and moral degeneration and the impending decline of America's civilization in the event of continued inaction to depopulate the unfit (Fong and Johnson, 1974: 102-103).

Fong and Johnson trace the development of the Human Betterment Foundation's policy toward the 'unfit' and argue that over time, and through the use of the media, leaders in the organization changed the "characterization of feeblemindedness from a scientific to a more socio-political concept" (1974: 106). Initially IQ tests were used (scientific concept) to determined feebleminded people, but when it became apparent that people of low IQ came from all races and social classes, the HBF determined that in addition to IQ feeblemindedness should also be determined based on "individual characteristics and history" (106). Using this definition of feeblemindedness allowed the eugenicists more discretion in deciding which individuals were necessary to the economic structure (the "desirable" feebleminded who came from the working/labouring class) and which were not. The latter group, the "undesirable" feebleminded, "was comprised of racial groups whom the HBF felt needed sterilization by virtue of their alleged innate inferiority" (Fong and Johnson, 1974: 106).

In Canada, psychologists and other mental health professionals were influenced in large part by their neighbors to the south in terms of their attitudes regarding race and immigration and the threat of the 'defective alien' (Polyzoi, 1986). Eugenics in Canada, as we saw earlier, was closely related to immigration issues. Polyzoi argues that psychologists often served to influence the Canadian government into adopting more restrictive immigration legislation. In fact, according to this author, "psychologists writing on the subject of immigration often worked from social and racial premises which served to color their examination of immigration, and thereby compromise their scientific impartiality" (1986:53).

Menzies illustrates the close connections between British Columbian provincial authorities and medical practitioners in orchestrating the deportation of "psychiatrically disordered and cognitively disabled" immigrants out of the province in the years between Confederation and 1939 (1998: 135). Eugenics and race betterment theories were influential in contributing to definitions of the 'immigrant insane' that in turn broadened the numbers and types of people who could be deported from the country. Amendments to the Immigration Act over the years made it easier to deport the 'alien threat'.

Tyner offers an analysis of "The Geopolitics of Eugenics and the Incarceration of Japanese Americans" (1998) that illustrates how the eugenics movement, which effectively combined growing racist and nationalist sentiments of the late-nineteenth and early-twentieth centuries, indirectly influenced the incarceration of Japanese immigrants and American citizens in concentration camps. Geopolitics and eugenics together make clear the close connection between racial proximity and territorial expansion (1998: 257). In the context of the bombing of Pearl Harbour, territorial expansion ignited already tense racial relations between the Americans and Japanese. According to politicians, academics and military strategists, "the maintenance of a healthy, vigorous state and the avoidance of race wars required the elimination – through sterilization, segregation, or immigration restriction – of the deviant and the alien" (261). In the aftermath of the attack, racial segregation was seen as the obvious solution. Eugenics entered the picture as a result of the long-standing concern over the reproductive ability of persons of Japanese ancestry (1998: 264). This analysis illustrates the importance of immigration and racist notions to any discussion of eugenics.

Eugenics and Institutional Preservation

This section reviews studies that deal with what I have referred to as the political or institutional level of analysis. Institutions and the superintendents of these institutions played a significant role in the eugenics movements. Often they had vested interests in certain policies and procedures. As such, this level of analysis provides us with an understanding of "agendas" that are not clearly obvious at the social structural or individual levels of analysis.

As some scholars have indicated, eugenic policies were not always about genetics and race betterment (Haller, 1963, Ladd-Taylor, 1997; Reilly, 1991; Trent, 1993). Sometimes sterilization operations for example, were performed not for eugenics, but rather for social reasons. As Ladd-Taylor argues, compulsory sterilization in the United States "had as much to do with taxpayer stinginess, controlling women's sexuality, and political expediency as with eugenics or the "rationalization" of reproduction" (1997: 138). It is no surprise that in times of social stress and economic difficulties, governments look at ways of cutting costs. When the 'feebleminded threat' was presented in terms of taxpayer burdens, it was appealing to turn to the more cost-effective sterilization solution, than the more expensive long-term welfare system alternative (supporting the feebleminded menace and her children). Ladd-Taylor observes that during the Depression, sterilization proponents "talked more about preventing the feebleminded from placing a burden on taxpayers than about preventing the transmission of genetic defects" (1997: 149).

The argument has been made that the eugenics movement was complicated by the operation of institutions whose superintendents often had their own agendas and tried to influence the direction of eugenics, segregation and sterilization policies (Trent, 1993). Trent suggests that superintendents' main concern was to preserve their institutions from what they perceived as threats, both internal and external to the institution. "As such, sterilization became a 'medical' procedure constructed not so much for its explicit purpose - stopping procreation, but for maintaining institutional order and preserving professional prerogative" (Trent, 1993: 58). In other words, not only the social-cultural context influenced sterilization and segregation practices, but superintendents - individuals with agendas - influenced the social control of the 'unfit'.

Radford (1994), in critiquing Trent's research, points out that Trent's perspective "seems to deny the complementarity of the 'inside' and 'outside' worlds" (Radford, 1994: 463). Radford argues for an analysis of the asylum as closely connected to broader social structures and processes. In rejecting Trent's view of the asylum as independent of and cut off from the rest of society, Radford says that "it seems particularly inappropriate that an account which stresses the use of sterilization as a measure of control inside the 'mental deficiency' asylum should seek to minimize the broader structures of social control of which the asylum is itself a part" (Radford, 1994: 472). My contextual social constructionist perspective will take into account the role that institutions and their superintendents play in the construction of the category of the feebleminded, and the response of society to such individuals.

Eugenics and Class

The following studies deal more with the targets of eugenics movements. In other words, in the language of my study, the focus is on groups of people at the interactional level. Were men or women targeted more? Were particular social classes or races the targets of the eugenics movement?

According to Lydia Morris, the 'underclass', individuals who stand outside of mainstream society, are sometimes perceived as a different breed of person. She argues that the idea of an underclass sometimes involves "a biological argument, sometimes a moral judgment, sometimes a view of changing class structure, and sometimes the idea of inadequate socialisation and a deviant 'sub- culture'" (Morris, 1994: 10). Those individuals targeted by the eugenics movement can be considered as an "underclass" of sorts. She explicitly points to genetics and the eugenics movement as an important influence in the social engineering philosophy and its attempt at dealing with such an underclass.

Theories of the underclass were established long before the eugenics movement came into existence. T. R. Malthus saw the "redundant population" as immoral. For him, "morality is seen as the basis of a good society, and moral failure the cause of poverty and distress" (Morris, 1994: 11). According to this perspective:

> Poverty is brought upon the sufferer by *his* own failure; the idea of state responsibility is politically disruptive, dishonest, and likely to end in despotism; poverty is spread by a sub-culture based on vice, filth and moral ignorance; public provision for the poor destroys the will to work; man is naturally indolent; the resolution to the problem lies in moral education and the enforcement of self-reliance (Morris, 1994: 12).

In opposition to Malthus, Marx argued that the surplus population is necessary for the functioning of capitalist society. He saw this surplus population of workers, not as morally defective, but as victims of the capitalist economy. Marx's lumpenproletariat, however, received moral condemnation and was considered different from the more legitimate working class proletarian.

Mayhew, in a similar vein, invoked a moral and biological account in attempting to explain unemployment and the existence of the underclass (Morris, 1994). He described the vagrant as socially, morally, and physically distant - as if they are a separate race. In this way, "a structural location is thus combined with a moral condemnation and racial distancing fuelled by the curiosity and social fears of the established middle-class population" (Morris, 1994: 19).

Contributing to these views on the underclass was Social Darwinism, which "focused as much on physical degeneration as on demoralization" (22). It was argued that the urban environment actually selected for and favored the survival of an inferior breed of human being. In particular it was argued that "a race of men, small, ill-formed, disease-stricken, hard to kill" (22) was surviving and reproducing at higher rates than the average, 'normal' citizen. It was images such as this one that contributed to the growing popularity of the eugenics movement. "Here we see fears of social disorder, of a burden on the public purse, and of immorality, tied together with ideas about hereditary degeneration and the popularised influence of 'social Darwinism'" (Morris, 1994: 23). It appears that conceptions of social class, and in particular, conceptions of the underclass, contributed to and fueled the rapidly growing eugenics movement, which ultimately aimed to rid the world of this unsavory element of society. The argument was for 'rational selection' as opposed to 'natural selection' (25).

The Case of Eugenics in Alberta

In keeping with the general stance toward research taken in this project, the studies that have already been conducted on the Eugenics movement in Alberta are presented and analyzed according to the socio-historical context within which they were written. The studies and their findings are situated within the time period they were written and are presented in chronological order as a way of documenting the progression of ideas and conclusions regarding the eugenics movement in Alberta[3].

"The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act" - by Timothy Christian.

This study (1974) begins with a detailed account of the forces and political processes leading up to and resulting in the enactment of the *Sexual Sterilization Act*. Through an analysis and examination of newspaper and magazine articles of the time, of meeting Minutes of various interest groups, of speeches delivered by prominent proponents of the eugenics cause, of sessional papers of the legislative assembly of Alberta, of other government reports, and of letters exchanged between people, Christian contextualizes the feeling of the time and the types of publicity the proposed Act was receiving. He also details the similar processes that occurred during the time leading up to the repeal of the Act in 1972.

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[3] Three earlier studies (C.A. Baragar, Geo. A. Davidson, W. J. McAlister, and D. L. McCullough. 1935. "Sexual Sterilization: Four Years Experience in Alberta". *American Journal of Psychology.* 91 (2): 897 – 923; R.R. MacLean and E. J. Kibblewhite. 1937. "Sexual Sterilization in Alberta: Eight Years' Experience, 1929 to May 31, 1937". *Canadian Public Health Journal.* 587-590; E. Mary Frost. 1942. "Sterilization in Alberta: A Summary of the Cases Presented to the Eugenics Board for the Province of Alberta from 1929 to 1941". Master's Thesis. University of Alberta) were conducted by people affiliated with the Eugenics Board and are discussed in a later chapter, as an example of how the Board "constructed itself".

One of the objectives of Christian's study was to conduct a "statistical analysis of available data compiled by the Eugenics Board "...in order to establish which of several criteria were significant in the determination of the Board to recommend sterilization of patients presented to it and to arrive at a description of the population that was dealt with by the Board" (35).

Christian conducted his statistical analysis on 430 Eugenic Board cases. His data source was the file system established by the Eugenics Board and, at the time of his study, maintained by the Mental Health Services Division of the Alberta Department of Health. Christian used the patient cards produced by the Board. These cards, pink for girls, blue for boys, summarized information from the larger Eugenics Board files kept on each patient. They were essentially a way for the Board to summarize patient files into a convenient system for easy use. The Board decided which information was important enough to be put on the card.

While Christian presents a detailed analysis of his findings, some of his main conclusions indicate that the Act was used primarily to control the weak and marginalized. McLaren summarizes the results of Christian's study as follows:

> Sixty-four per cent of those sterilized were women, 60 per cent were under the age of twenty-five (20 per cent were less than sixteen), and the majority were single and unemployed or unskilled. Once the consent provision was ended in 1937 a disproportionate number of Roman Catholic and Greek Orthodox patients were treated. Among those both approved for and ultimately sterilized eastern Europeans were overrepresented and Anglo-Saxons underrepresented. But the clearest evidence that differential treatment was meted out by the Alberta Board of Eugenics is provided by an examination of its care of Indian and Metis patients. In the last years of the Board's activities, Indians and Metis, who represented only 2.5 per cent of Alberta's population, accounted for over 25% of those sterilized (1990: 160).

It was the status discrepancy between the average Alberta citizen and the one deemed worthy of sterilization that seemed to matter. Christian's work was completed shortly after the *Sexual Sterilization Act* had been repealed (1972). He has been accused by Gibson of using "hyperbole" in his report. However, if we consider the time period during which he was writing, we can understand his outrage and desire to illustrate the inconsistencies and injustices of the Board. Christian uses statistics in making his argument. However, he takes a step closer to the social constructionist approach by quoting historical documents in telling his story of the eugenics movement. By drawing on newspaper articles, government documents, sessional papers and other historical records, he essentially constructs the process leading up the passage of the *Sexual Sterilization Act*. He does the same for the process leading up to the repeal of the Act.

Ready or not; like it or not: Mentally unfit citizens face the "Board"- by Dr. D. Gibson.

While I cannot find the date of this study, it is apparent that it was written some time after Christian's, perhaps in the late '70s or in the 1980s. In his study, Dr. D. Gibson makes the argument that blame for the wrongful sterilization of Alberta citizens should not be placed solely on the shoulders of the Eugenics Board. Rather, he argues others, for example, the referring agencies who provided cases for Alberta institutions and therefore for the Board, are also guilty.

Gibson takes issue with much of what Christian found in his study. In fact, Gibson refers to Christian's report as overusing 'hyperbole' (141). Gibson bases his report on a revisitation of reports such as the one by Christian, "in the context of our fuller case book, and Board records of proceedings" (141). Gibson looks at the sex bias found in earlier studies, as well as the occupational, religious, and ethnic biases documented by other researchers. He finds, for the most part, that other agencies, in addition to the Eugenics Board were responsible for the processes that occurred under the administration of the *Sterilization Act.*

As part of the social constructionist approach used in my study, this issue is also given attention. It is important to investigate and to understand at which level in the 'eugenic funnel' people were most actively creating the 'menace of the feeble-minded', and at which point in the 'funnel' were they most actively trying to 'deal' with the problem'. In other words, a comprehensive look at the social construction of eugenics must try to identify where it was in the 'funnel' that the constructed image of the problem was most influencing peoples' actions.

Gibson's study also had as a goal the identification of the "process and the motives employed in reaching a decision to sterilize" and "to identify the mistakes made, the characteristics of persons referred to the Board, and the consistency of the Board's decision process with those criteria spelled out in the Sterilization Act" (150). Gibson acknowledges the existence of both formal and informal criteria in shaping a given Board decision. The study is based on an analysis of "sixty-four consecutive case histories and sets of interview notes kept by Board members during their meetings, feeding the decision for or against involuntary sexual sterilization of a mentally handicapped child or young adult" (151). A similar analysis was conducted on data for thirty-two mentally ill people.

Gibson, among other things, found that sterilization could be and was approved without evidence of genetic risk to any future progeny. Rather, being fit to 'parent' was increasingly a more important concern to the Board. "Hence, social and welfare considerations became sufficient for sterilization to be carried out" (151). Specifically, in the sixty-four cases analyzed ('mentally retarded' cases), "in none was there adequate clinical or scientific evidence of heritable disorder" (153). Gibson found that in 52 per cent of the cases presented and approved for sterilization, there was evidence of non-genetic mental handicap (154). For twenty-seven per cent of the cases, the case histories were "too limited in family, behavioural, and medical data to warrant a judgment about the origins of a given mentally handicapping condition" (154).

Gibson, arguing that the institutional populations were distorted because of the processes and activities outside the realm of the Board's jurisdiction, states that "referral for sexual sterilization served primarily the convenience needs of the care agents, had little to do with eugenic doctrine and was peripherally related to patient social welfare concern for those about to be released to the community" (173).

Gibson was writing at a time when the Act had been long repealed. Hence he is less concerned with "hanging" the Eugenics Board and more concerned with looking at how other agencies were involved. While Christian focussed much attention on the processes leading to the passage of the *Sexual Sterilization Act*, Gibson focuses his work in part on the labelling processes to which patients were subjected. He looks at the role of institutions, but also at the way in which the Board reached its decisions regarding sterilization. As with Christian, we see Gibson taking another step closer to the social constructionist perspective. Christian primarily constructed the process leading up to the passage of the Act. Gibson primarily constructs the activities of the institutions and the Board in reaching sterilization decisions.

"From the Case Files: reconstructing a history of involuntary sterilisation" - Deborah C. Park and John P. Radford

This article provides a very different perspective on the Eugenics Board and its activities. Perhaps as a sign of the times, this article, published in 1998, uses discourse analysis in analyzing the ways in which case files were used to construct certain people as members of problem populations. Whereas the other studies, for the most part, focus on the inception of the *Sterilization Act*, and on aggregate data regarding such issues as sex, ethnicity, occupation, and various behaviours, this study uses a case study approach to "present the case made for involuntary sterilisation from professional, often custodial perspectives" (317). Using clinical reports, diagnoses, test results and patient histories, the study provides us with glimpses of the personal lives of individuals recommended for sterilization, as well as providing us with a context within which the sterilizations were justified and sanctioned. In this sense, this article, the most recent of all of the articles reviewed in this section, is social constructionist in nature.

The Park and Radford study is based on Eugenics Board case files for Alberta sterilization measures between 1929 and the late 1960s (321). The authors examine the historical narrative contained in such case files and in so doing, "gain insight into the manner in which individual lives were constructed from a historical perspective" (321). The study exposes the "ambiguous social, economic, and cultural rationales behind sterilisation activity" (321). Sterilization in Alberta essentially served as a biological 'solution' for a variety of social and behavioural problems. The article provides detailed excerpts from actual case files which illustrate these points.

Summary

This chapter began with a presentation of the social constructionist perspective and an overview of some social constructionist research. I argued that a constructionist stance is perhaps most appropriate for a study on the eugenics movement, and in making this argument I discussed previous work on the eugenics movement, including three studies that used data from Alberta. In addition to these topics, I outlined the role of the helping professions and the vested interest they had in the social movement leading up to the eugenics program in Alberta and continuing throughout the duration of the eugenics program. Finally, the ways in which the eugenics movement was influenced by and in turn influenced socio-cultural trends, gender issues, class concerns and institutional arrangements also was discussed. The chapter is intended to provide background and justification for the theoretical perspective taken in the study, but also to survey at least part of the extensive amount of work conducted on the topic.

These studies discussed have all dealt with eugenics, and some specifically with the case of the Alberta Eugenics movement. How does my study differ from these other works? First and foremost, this study uses an integrated framework to present a social constructionist case study of the Alberta Eugenic Movement. My goal is a comprehensive understanding of the movement as an example of the social control of deviance. While other studies on the topic have used aspects of the social constructionist perspective in examining the problem, not all have been as self-conscious about this stance. In other words, studies conducted several decades ago did not have the benefit of social constructionist research completed since then. Such studies were essential to the building of the social constructionist literature. My study can benefit from the wealth of work done from this perspective, including those studies on the eugenics movement conducted throughout the years. This study explicitly incorporates a multi-level component to the analysis. Three levels of analysis are addressed: structural, institutional, individual. While the other studies mentioned focused on one or two of these levels, this study aims to comprehensively integrate aspects from all three. In this way, it goes beyond other research conducted on the topic.

This study also incorporates a comparative analysis into the understanding of the eugenics movement in Alberta. Comparisons can be made with, for example, Christian's work. Do we paint the same picture of the processes leading up to the enactment of the *Sterilization Act*? Will we find the same biases occurring in the types of people sterilized? My study is grounded in a more complete data set than previous studies. In addition to this, multiple sources of data are used as part of the multi-level analysis. For example, I use the complete data set of which Christian used a sample. Christian and Park and Radford did not focus on the Alberta Eugenics Board meeting Minutes, but I do as part of the institutional level of analysis. Because of the more extensive number of cases analyzed and sources of data used, this study may reveal themes not discovered in previous research. Because of the multi-level analysis, agendas and activities of different social control agencies may prove to be similar or different, something not addressed in previous studies.

In other words, the objective of this study is to provide a more integrated, comprehensive analysis of the ways in which the eugenics movement and feeble-mindedness was socially constructed in Alberta between 1929 and 1972. Having this broad overarching thesis is valuable for several reasons. The nature of the data allows us to analyze various components of the eugenics movement and the Alberta Eugenics Board. We have access to more data sources than previous studies. Data are available from various different levels (i.e. the Board itself, the institutions involved) which allow for a more complete picture of the events and processes occurring during this period of time. In approaching the topic of eugenics, the present study has the added advantage of building on the wealth of previous studies. This involves reinvestigating previous hypotheses with a larger, more representative data set. It also involves building onto these studies by asking new research questions that build on prior findings. This may include discovering new themes and relationships between the actors involved. Previous studies are used as a jumping off point with the goal of trying to attain a more integrated perspective on how the various components worked together (or against each other) during this time period.

Chapter 4: Methods

This is certainly not the first study to be done on the Eugenics Movement in Alberta. For example, Park and Radford (1998) conducted a narrative analysis of some of the formal institutional documents to discover general themes that dictated the way in which patients were "constructed" by mental health authorities at the time. Christian (1974) completed a quantitative analysis of some of the data contained in the archived case study cards. These and other studies provide glimpses of the process; they focus on certain aspects, specific activities, and particular samples.

One objective of my study is to provide a more comprehensive look at the Eugenics Board and its activities. In other words, my study builds on these valuable earlier studies by incorporating more cases and additional sources of information. As discussed below, I have access to a database that contains information on all of the people ever presented to the Board. None of the other studies cited reported on such an extensive database. My study also combines quantitative analyses with qualitative interpretations in order to better "tell the story" of the Alberta Eugenics Board.

While going beyond previous studies, my research, in a sense, remains an exploratory case study, one that investigates the extent and nature of the social construction of the "problem" of feeblemindedness. Thus, my study does not constitute a test of a specific theory or set of theories. Rather it draws on various perspectives to unravel the types of "constructive" processes and the types of social constructions produced by the people and organizations involved.

It was through my association with the Population Research Laboratory as a research assistant that I became involved in the data collection process for this project. The Population Research Laboratory (PRL) is a research organization affiliated with the Sociology Department at the University of Alberta. It contracts with academic researchers and non-profit organizations to conduct surveys, interviews, and various other research projects. Two Edmonton law firms (Field Atkinson Perraton and Parlee McLaws, hired to represent some of the plaintiffs in the suit against the Alberta government described in Chapter One) contracted the PRL to construct an electronic database from available records concerning the Alberta Eugenics Board. They suspected that there were certain biases and inconsistencies in the way in which the Board had conducted its business, evidence of which would have enhanced their case had it gone to trial. Because of my contributions to the PRL report for this contract, some of the material from the report has been reworked for presentation in this study.

The background and historical material used in telling this story are largely taken from secondary sources. In particular Angus McLaren's text *Our Own Master Race* (1990) provides a very detailed historical account of the eugenics movement in Canada, as well as comprehensive information on key players in the movement. Timothy Christian's study (1974), while providing one of the first quantitative looks at the activities of the Board, also presents a valuable account of the events leading up to the passage of the *Sexual Sterilization Act*, as reported in media and government documents of the time.

Another important source of historical information for my study has been the Alberta Public Health Records. These official annual reports on the activities of the province's mental health institutions and the Eugenics Board have provided both qualitative and quantitative information useful to the present study. Census information was also used in calculating statistics regarding the relative proportion of certain ethnic and religious groups that came before the Board, as compared to their numbers in the general Alberta population.

By drawing on these secondary sources, my goal is to augment or complement the databases used in the study. As with any "story" there are various components or sides to it. In order to provide a more comprehensive analysis of this constructed social problem and the legislated medical "cure" for the problem, various sources of data are used. These data sources are based in large part on the various paper trails left by the Alberta Eugenics Board and the provincial mental health institutions that were affiliated with the Board.

The Method

This study is a social constructionist case study. It illustrates how one group of people was able to label and control other groups based on what were perceived to be the latter's "defective" characteristics. Some of the data lends itself to a quantitative presentation of parts of the story. Crosstabs, frequencies, and probabilities are therefore used in the telling of this story. Other data are qualitative in nature and so are better analyzed using discourse analysis. Before further describing the types of data used in the study and the ways in which these data were analyzed, I first explain the epistemology informing this project.

Some of the quantitative analyses are more straightforward than other parts of the analysis. By straightforward I mean they offer an understanding of a part of the story in terms of frequencies. Ninety-nine percent of people who appeared before the Board were approved for sterilization. This is a straightforward fact, teased from the information available to us from Board Minutes and case files. However, how does one interpret the fact that for one patient there was no significant family history (in terms of genetic disorders in immediate and distant relatives), a sexual history that involved promiscuous behaviour, and a diagnosis of "borderline intelligence"? How does one explain the treatment of such a case in 1935 as compared to a similar one in 1966? This is where the story gets complicated and frequencies and percentages lose some of their explanatory power.

This is why part of the story is told through discourse analysis. As we will see shortly, the discourse being analyzed is actually a type of narrative, a narrative written by the secretary of the Eugenics Board and approved by its Chairman. Another narrative was written by the staff members of the mental health institutions. The story I am telling is a narrative twice removed. The patients involved have a story, the story of their lives leading up to and including involvement with the Eugenics Board. We have access to their stories through the interpretation of the professionals who recorded these stories in a particular narrative format, the official documents of the institutions and of the Eugenics Board. In other words, the lives of the patients have already been constructed once by the institutional staff who have picked and chosen what was relevant to their construction process (and for the purpose of making the case for sterilization). Now, I am reading the staff's narrative accounts and constructing my own narrative account of the Eugenics Board and the characteristics of the patients involved. As Schwandt states "the constructs of the social sciences are constructs of the second degree…constructs of the constructs made by actors on the social scene" (1994: 121).

While we can never really know what the people involved were thinking at the time that they were making decisions, and leaving these documents behind, we can try to intelligently infer what might have been going on at the time that would contribute to their thinking process. A social constructionist approach, as Gergen states, is

> principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live. It attempts to articulate common forms of understanding as they now exist, as they have existed in prior historical periods, and as they might exist should creative attention be so directed (1985: 266).

Part of the process by which people described what they were doing included the Minutes of Eugenics Board meetings and also the case files of patients who appeared before the Board.

Importantly, from a social constructionist perspective, what the people at the time observed as and inferred to be social order was more a product of their own construction of reality than of an inherent property of social reality. "All symbolic universes and all legitimations are human products; their existence has its base in the lives of concrete individuals, and has no empirical status apart from these lives" (Berger and Luckmann, 1966: 118). Feeblemindedness was constructed to be a threat to Albertans. As Berger and Luckmann state: "To understand the state of the socially constructed universe at any given time, or its change over time, one must understand the social organization that permits the definers to do their defining" (1966: 107). We saw this in Chapter Two with examples of the inflammatory rhetoric and exaggerated statistics regarding mental defectiveness and immigrants. We see more examples of this in the following chapters. It is through the constructed narratives left behind that I construct my own story of the Eugenics Board and its activities.

How do I as researcher fit into the picture? What reality am I constructing? And what right do I have to do so? These concerns stem from the idea that "language is a *constitutive* force" (Richardson, 1990: 12). Through language one creates a particular view of reality. The narrative mode of writing and analysis is contextually embedded; such analysis looks for connections between events. "The *connections* between the *events* is the *meaning*" (1990:13). Furthermore, regardless of how I tell the story of eugenics, I am using grammatical, narrative, and rhetorical structures that "construct the subjects and objects of [the] research, bestow meaning and create value" (1990: 12). Values are important to the constructing process. Writing involves "the ownership of the means of enunciation" (1990: 12). In other words, as writer/constructor I have power – the power to inscribe values into my writing/construction.

> When we write social science, we are using our authority and privileges to tell about the people we study. No matter how we stage the text, we – as authors – are doing the staging. As we speak about the people we study, we also speak for them. As we inscribe their lives, we bestow meaning and promulgate values (1990:12).

As author, one has power, the power to tell the story according to one's own values and beliefs. The fact that I am not a member of the group whose story I am telling raises interesting questions. Essentially I am taking up the story of a group of people from a different time, who were in a different situation than I, and I have nominated myself as spokesperson. I have somehow become the spokesperson for the entire eugenics movement – from Francis Galton, to James MacEachran, to Leilani Muir. I myself will single-handedly construct all of their stories. This raises several issues with which I must reconcile myself. For whom do I speak, to whom do I speak, with what voice, to what end, using what criteria (1990:27)?

Power figures prominently in this entire analysis. I point to power differentials between labeller and labelled in the eugenics movement. In the analysis below I discuss the importance of the power of surgeons, of Board members, of the media and interest groups; the lack of power of the feebleminded and the mentally ill, of youth and of women. In all fairness, I must also acknowledge, analyze and reveal the extent and nature of my own power in this analysis.

As Richardson points out, "the stilling of the sociologist-writer's voice not only rejects the value of sociological insight but implies that somehow facts exist without interpretation" (1990: 27). Speaking for others is inevitable; the "facts" are not going to jump out on their own. A mediator/creator is necessary. Writing is intentional behaviour. And intentional behaviour is a site of moral responsibility. There is no way of knowing the "right" story of eugenics; a "right" story of eugenics may not even exist. The best I can offer is "my" story of eugenics in Alberta based on my immersion in the data collection process for 18 months, and the analysis process which took another two years. To quote Richardson: "...because power differences are always being played out in personal and civic arenas, there is no way to avoid deploying one's power if one chooses to act/write in this world" (1990: 27). The best I can do is be aware of the power relationships of which I am a part in this process. Part of this awareness includes asking myself how writing this thesis reproduces a system of domination and how it challenges such a system (1990: 27).

One goal in telling the story of the eugenics movement in Alberta might be to give voice to those who have been silenced (this might be called the "progressive" viewpoint). Another, the postmodernist viewpoint, might deconstruct the events and the stories of the people involved, to "delete the author, to dismantle distinctions between fact and fiction, and to deconstruct differences between sign and signified" (1990: 27). I choose to agree with Richardson:

> A progressive-postmodernist rewriting, however, proposes that, because all knowledge is partial and situated, it does not mean that there is no knowledge or that situated knowledge is bad. There is no view from "nowhere", the authorless text. There is no view from "everywhere" except for God. There is only a view from "somewhere", an embodied, historically and culturally situated speaker (1990: 27).

In making this choice, I have decided to speak as narrator or storyteller. As narrator, I do have "a" point of view. I am "an embodied person responsible for [my own] words" (1990:27). In this sense, this study is written from the point of view of a situated, positioned author who has chosen to give up *authority* over the people studied, but not the responsibility of *authorship* of this text (1990: 28).

Finally, a word about the type of narrative I have written. This study might be considered a "collective story". "The collective story displays an individual's story by narrativizing the experiences of the social category to which the individual belongs, rather than by telling the particular individual's story or by simply retelling the cultural story" (1990: 25). This is a story of how one group of "underdogs" came to be labelled and controlled by another group. It is a story of how one collectivity was constructed as a threat to society. The story has parts that are relevant to any individual who at some time or another has been labelled. It is a story about a particular collective – those people who came before the Eugenics Board. But it is also a story about any collective or individual who can relate to such treatment. Being labelled and controlled is a story that has relevance to many different social categories and groups of people. As such this is a work of moral activity. It is an attempt at textual enfranchisement of the previously (and currently?) disenfranchised (1990: 64). As such it may be that the story being told in the following pages says as much about me and the social context in which I operate as it does about the behaviours I am studying. This leads to a question regarding objectivity and subjectivity regarding the social construction of feeblemindedness and the activities surrounding it. This issue was touched on earlier when we discussed constructivists' stance on reality. For the social constructionist, reality is constructed through human action.

> "Objectivity", thus, is not innate to any state or condition of the world, but reflects the intersubjective consensus attained within particular community contexts with respect to this or that aspect of the life-worlds to which particular sets of people attend (Prus, 1996: 88).

Knowledge represents a "historical-collective enterprise produced by a community of people interacting with one another" (88). As more people reach conclusions regarding the same types of constructions some degree of consensus is reached regarding the issue. "Knowledge becomes more firmly entrenched as "objective reality" as people develop, act upon, and transmit these versions of knowing to each other" (89).

In other words, everything that passes as "knowledge" is thoroughly and fundamentally a product of social exchange (89). Furthermore knowledge accumulates in a relative sense only. As different constructions are brought into juxtaposition, ever more informed and sophisticated constructions are developed (Guba and Lincoln, 1994: 114). The constructivist stance on methodology is described as *hermeneutical and dialectical* (111), which essentially means that "individual constructions can be elicited and refined only through interaction *between and among* investigator and respondents" (111). Then, these constructions themselves are compared to one and another in a distilling process, the end product of which is to produce a consensus construction – a *social* construction. The goal is to reconstruct previously held constructions. In this sense 'knowledge' of 'reality' is ever changing and developing. "Truth is a matter of the best-informed and most sophisticated construction on which there is consensus at a given time" (Schwandt, 1994: 128).

One of the main criticisms leveled against constructionism concerns charges that such accounts are only the account of *one* researcher. Similarly, the charge laid might concern relativism: all accounts are equally good or bad, so which is the 'right' one? How can the researcher embrace or avoid the tendency to "judge" or evaluate the merits or drawbacks of eugenics and sterilization? Since constructionists are united in the claim that the idea of an 'objective' reality is nonexistant in the positivistic sense, they have addressed these charges in different ways. In drawing on these 'defenses', I too defend the approach taken in this study. One way of addressing the charge is to focus on methodology. Procedural criteria become one means for judging the goodness of interpretations (Schwandt, 1994: 130). "Hence to judge an interpretation we might use criteria such as thoroughness, coherence, comprehensiveness, and so forth, and ask whether the interpretation is useful, worthy of adoption, and so on" (122). Furthermore, the criteria include the goal of constructing something "that fits together and handles new cases, that may implement further inquiry and invention" (127).

Guba and Lincoln propose two additional sets of criteria to judge the goodness or quality of an inquiry.

> The trustworthiness criteria of credibility (paralleling internal validity), transferability (paralleling external validity), dependability (paralleling reliability), and confirmability (paralleling objectivity) and the authenticity criteria of fairness, ontological authenticity (enlarges personal constructions), educative authenticity (leads to improved understanding of constructions of others), catalytic authenticity (stimulates to action), and tactical authenticity (empowers action) (1994: 114).

A second way to address the criticisms leveled at constructionism is to "admit" subtle realism (Schwandt, 1994: 130). The argument is that there is something beyond the construction or interpretation which ultimately determines the construction. In other words,

> there can be multiple, non-contradictory descriptive and explanatory claims about any phenomenon without denying that if those interpretations are accurate they must correspond in relevant aspects to the phenomenon described (130).

The 'reality' is that over 2800 people were sterilized in Alberta. Any constructions created from the historical documents available will in some sense be 'grounded' in that reality. Different researchers studying the problem may come up with different constructions, but at some point they must all agree that thousands were presented and sterilized. "Hard" constructionists would take issue with this allowance for "reality", but "soft" constructionists, who I align myself with, would not.

Having said that, it is my belief that because of the nature of the present study, the data available, and the interpretations made of this particular social problem, others who may conduct a constructionist study of the eugenics movement in Alberta will come up with similar constructions to mine. In other words, the 'results' of this study make it a 'social' constructionist study – multiple constructions might add to the strength of the story, but most would come to some consensus in terms of constructions. Is there 'a reality'? Yes. Might some researchers offer alternative descriptions and explanations of such a reality? Yes. Is it possible for a several researchers to analyze the same data and offer similar interpretations of this reality? Yes.

The Data

In addition to the secondary historical sources already discussed, there are three sources or levels of data collection that are relevant to this study. Each of these sources is discussed in some detail. Following this, I describe the ways in which the data are used to tell the story.

Meeting Minutes

I first became aware of the material out of which this study arises as a result of my involvement as research assistant in a project conducted by the Population Research Laboratory at the University of Alberta. The PRL was contracted by two law firms, Field Atkinson Perraton and Parlee McLaws, to produce a report that would be used as evidence in a court case involving sterilization victims and the government of Alberta. The original documents are available in the Alberta Provincial Archives. The same documents had also been used as evidence in the Leilani Muir trial (mentioned in an earlier chapter) with the names of the sterilization victims edited out. After completion of the contract with the PRL, I continued my examination of the documents via access to the Muir exhibits held by Field Atkinson Perraton. This study relies only on the information available in the Muir exhibits, to which I was allowed access by the kind permission of Ms. Muir (*Muir v. Her Majesty the Queen)*.

The Minutes of all of 395 Eugenics Board meetings conducted between 1929 and 1972 were read and systematically coded early in the course of this study. The meeting Minutes were coded for such things as lists of people present at each meeting, who presented the patients, decisions made regarding each patient, administrative concerns, correspondence with outside organizations and individuals. While certain of these newly created variables have been coded using a limited set of categories, many variables are "string" variables, with the information recorded verbatim. As well, correspondence (letters, articles, reports) attached to the Minutes has been either paraphrased or recorded verbatim. This Minutes database can be linked to the basic file database discussed above. For example, one can find out at which meeting a particular case was presented.

For the textual analysis presented in Chapter Six, I went back to the original Minutes and read through them again, recording what I thought were significant paragraphs, sentences, phrases, and incidents. As well, I recorded the names of the people present, the number of patients presented, and the date and location of the meetings. By reading and rereading the original documents rather than using the more quantified database for the discourse analysis, I tried to get a better feel for what the Board was doing and saying. Somehow, looking directly at the documents and signatures allowed a more empathetic understanding of the Eugenics Board and its activities.

Similarly, correspondence attached to the Minutes was read and re-read with the same goal in mind – trying to discern themes and attitudes regarding the issues facing the Board. Frequently correspondence was from individuals or groups applauding or disparaging the Board's work. More often than not, the correspondence had to do with institutional concerns and procedures. In this way, I was able also to learn more about the Board's relationship with the mental health institutions and with the Government departments directly connected to the Board.

Basic File

This data file includes the names of all 4785 individuals presented to the Eugenics Board over the course of its operation. The file has been organized according to the Eugenics Board number assigned to each case by the Board[1]. These numbers were assigned sequentially. Also included with each name are the date of presentation to the Board and the date of sterilization, if sterilization occurred. As well, the individual's sex is included. Once this initial list was created, information on the "presenting institution" – the hospital or training school that officially "presented" each patient to the Board – was compiled from other sources as well. These other sources include the Eugenics Board meeting Minutes and the case files, both discussed in more detail below. If patients died or were deported, this date is also included.

Case Card Summaries

A total of 861 of the 4785 cases presented to the Board were also coded into what I will refer to as the '1 in 5 sample/file'. After the Board was forced to discontinue its operations in 1972, many of its files, including all the case summaries (detailed files on each patient) were placed in the Provincial Archives. In 1987, the Provincial Archives recommended that only a 20% sample of the files be kept, presumably to reduce the amount of paper being stored while still retaining a cross-section of the documents on file. Between April 1 and June 2, 1988 all but 861 of the original 4785 files were destroyed.

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[1] For the purpose of this study, Eugenics Board numbers have been changed. As well, information that could be used to identify individuals has been omitted in order to ensure anonymity.

The '1 in 5 sample' contains some very detailed information. Each of these files includes a "presentation summary". This one to two page report covers largely standardized types of information. This includes the particulars of each patient's history and current behaviour. The report provides personal information such as full name, next of kin, address, occupation, religion, ethnicity (racial origin), date admitted to institution, date presented to the Board. The remaining portion of the form is divided into a section on the physical examination of the patient, family history, personal development, educational attainment, economic history (occupational history), psychometric testing (if done), personality, social and sexual (and in the earlier years, moral) history, past illnesses, present illness/condition, attitude of patient (to sterilization), attitude of parents or spouse (to sterilization, if applicable), reasons for sterilization, and in the more recent cases, the decision of the Board (see Appendix 4 for an example of a presentation summary).

Also included in the file is a case card summary, which summarizes the information from the presentation summary - boys got blue cards, girls got pink[2]. Each file also contains each of the four or five required administrative forms[3], some contain consent forms, and many include additional correspondence relevant to the case. For example, if a former patient wrote a letter requesting his/her sterilization operation to be 'undone', the letter and response from the Board is included. Some of the case files include social worker follow-up reports, police reports, or additional medical reports.

All of the information contained in the "presentation summaries" and case card summaries has been entered into the '1 in 5 sample' database. Coding categories were developed which capture the diversity of information contained in these files. Where a limited number of closed categories were not feasible, information was recorded verbatim from the presentation summaries into the database. For this reason, descriptors like sexual history, family history, medical history, and social/personality history are recorded word for word in the database.

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[2] Timothy Christian used a sample of the case card summaries in his study on the eugenics movement in Alberta (1974). Please see Appendix 4 for an example of a case card summary.

[3] A form was filled out in order to have the patient presented, another form directed the type of operation to be done, another form reported the conditions under which the patient was approved for sterilization, and another form reported on the operation.

The '1 in 5 sample' is a representative sample of the 4785 files. There are a few inconsistencies in the sequential numbering of the '1 in 5 sample'. For example up to 1944, it is more like a '1 in 6 sample'. However, after 1944, it is in fact a '1 in 5 sample'. In addition, there are a few minor deviations from either the '1 in 5' or the '1 in 6' sequence over the years, along with one larger gap of 95 cases (around 1945). While the '1 in 5 sample' is not a perfect systematic sub-set of the total population of 4785 cases presented to the Board, the 861 cases are a highly representative sub-sample. They were used in the PRL report and are used in this project to generate estimates of population characteristics as they were intended to be used by the Provincial Archives.

Time Period

We will see in the following chapter that the Board was most active in the 1930s, its first decade of operation, and in the 1950s and 1960s, decades when greater numbers of younger patients were presented and sterilized. The present study focuses on these particularly active periods of time in the Board's history. Specifically, the 1940s are omitted from parts of the analysis, as are the years 1970-1972, the last years of operation of the Board. While an analysis of these years would definitely help to provide a more comprehensive understanding of the Board's activities, time and space restraints made it necessary to leave out something. Since the 1940s and the "1970s" are decidedly different from the other years in terms of Board "production" (presentations and sterilizations), I decided to leave them out – for now. Also, the 1940s contained a gap of about 95 cases in the 1 in 5 sample. Although the impact on the representativeness of the total sample is not significant, this gap, combined with the fact that this decade includes the war years as well, makes this a decade slightly different from the others.

Variables

Most of the constructed variables in the individual-level data-base are fairly straightforward, particularly for the quantitative analyses. For example, either one is sterilized or not. One can have children or one cannot. One's tubes have been tied/cut or not. With the exception of a very small minority of cases where sterilized people actually went on to have children, and had to be represented and re-sterilized, this is an easy variable to measure.

Many of the factors that may have influenced presentation and sterilization (e.g., gender, ethnicity, age) were laid out in a standardized format. Every individual presented to the Board had a case card summary and a presentation summary that listed his or her date of birth, ethnicity, religion, and urban/rural residence among other characteristics. Since these forms were filled out by institutional staff and were part of the patient's official mental health file, we assume that they are as accurate as can be expected with any official document of this nature and from this era. Of course one could argue that with any of this information, we do not know for sure if the patients gave this information directly, or if it was inferred by staff members. The point though, is that the information that was recorded, completely valid or not, is what influenced the Board's decisions. My goal is to see how the Board used this information to make its decisions regarding certain groups of people. The person's "actual" ethnicity was irrelevant. If an individual was constructed and labeled as a "Ukrainian-Cree half breed" by the institutions and the Board, then for all intents and purposes that is what the person was.

Coding

Most of these influential factors or predictors were coded using a standardized coding scheme. Coding the data took about a year and a half. There were three people involved in the coding process. A codebook was devised based on preliminary overviews of the data to be coded. As coding progressed, coding categories were changed to accommodate new discoveries and/or complications with the data. When these types of decisions were to be made, group meetings involving the coders, the project supervisors, and data analyst would be held. The three coders worked in the same office; when dilemmas were faced regarding coding or the "translation" (i.e., deciphering of handwriting) of handwritten documents, the three coders would discuss, debate, and draw conclusions as a team. As well, the coders would frequently double check with each other to make sure that consistency in coding was maintained. In this way, the goal of inter-coder reliability was addressed and maintained. When concerns regarding validity of coding categories became apparent, group meetings were held immediately and dilemmas resolved. For example, initially "reasons for sterilization" was to be coded as a string variable. It became obvious as coding progressed that there were about ten categories that were used throughout the years of operation of the Board. So the decision was made to change this string variable into a closed-ended variable.

String Variables

Two of the predictors analyzed in this study are string variables with which a discourse analysis is conducted. Specifically, family history and sexual history are used in this analysis. They are treated as important predictors because it is hypothesized that they had a significant influence on determining who was presented for sterilization. In this way they influence what it is we are trying to explain – determinants of sterilization. However, they are not analyzed in the same way as other predictors in this study (e.g., age, ethnicity). Rather, they are analyzed as narratives in an attempt to see how, combined with the Minutes of the Eugenics Board, they help us understand the process that led to presentation and eventually sterilization.

Family history is used in the analysis because the eugenics movement was concerned primarily with genetic conditions that would be passed on from parents to children. Hereditary weakness was to be "bred out" of the human population in much the same way that cattle were bred to produce healthy offspring. Family genes, family conditions and family history were a major concern of the Eugenics Board. The information was recorded in paragraph format. In this study, it is analyzed as a form of discourse that should provide insight into the way the families of these patients were constructed as being a problem.

Sexual history was also a primary concern of the eugenics movement. The rhetoric of the movement was about sex and reproduction, specifically, the reproduction of "sick" and "weak" offspring. Eugenics was inextricably tied to the notion that many members of the "underclass" were promiscuous and reproduced at a faster and more prolific rate than "normal" people. In other words, sexual history was integral to a patient's history in the eyes of the eugenics movement and the Eugenics Board.

Research Questions

This case study attempts to understand many different factors that contributed to the construction of the problem of the feebleminded in Alberta in the first half of the 20th century. As I mentioned earlier, there are no real hypotheses to be tested. This is not a standard "test" of a theory. Rather, I begin with some general research questions.

The critical research questions with which I began often led to new questions, some explicit, others passing thoughts that led me in another direction. In other words, conducting this research was like being a detective –following hunches, exploring some clues that might lead to more clues or might lead to a dead end. At any rate, by emphasizing the three levels of analysis and by pursuing answers to the following sets of research questions, I was able to impose at least a minimum amount of structure to my adventure. The first set of research questions has been addressed already in Chapter Two. I am presenting it here however, to illustrate how it led to the findings described in Chapter Two.

1. What was the general social milieu at the time of the eugenics movement? How did this atmosphere contribute to the identification of certain groups who were defined as being "problem populations?"
    a) Which individuals and groups were active in constructing the problem of the feebleminded?
    b) How did individuals and groups use the media to construct the problem? What tactics were used?

2. How was the *Sexual Sterilization Act* passed? How did the Eugenics Board carry out its mandate?
    a) Who was on the Eugenics Board? How did it operate?
    b) Once in place, how did the Eugenics Board contribute to the construction of the problem?
    c) Did the Board's activities change over time? If so, how?
    d) How did these changes contribute to the construction of the problem?

3. Who was targeted by the movement, the institutions, the government and the Board? In other words, who were the victims of this movement? Who were the deviant groups that had to be controlled?

   a) Are there discernible patterns/trends in who was presented to the Board over the years of its operation? How do these constructions tie into the activities of the Board (2c)?
   b) Did the constructions of "appropriate" targets change over time? If so, how? Did the constructions on the part of the institutions change over time? Were these constructions similar to those of the Board?
   c) How did the Board control these populations? How did the methods of control complement the constructions?
   d) Did these targeted/labeled individuals exhibit any resistance or agency in dealing with their labelers?

4. Why did the Eugenics Board remain in operation for as long as it did?
   a) Was Alberta really a hotbed of delinquency, crime and feeblemindedness? Or was the existence and longevity of the Board related to other factors?
   b) How did the Board itself contribute to its own longevity?
   c) How did the Board construct itself and the need for its existence?

Qualitative Analysis

The qualitative analysis of the Eugenics Board meeting Minutes and the case card summaries really began while I was coding this information in my role as research assistant for the PRL. I read through and double-coded the meeting Minutes. My role also included typing into the database all "other business" and correspondence attached to the Minutes. As such, I had to thoroughly read through the Minutes and comprehend what was "ordinary, daily business" and what was considered "other business". As well, by reading through and typing the attached correspondences, I began to understand what some interest groups and individuals thought about the Board, how patients and their family members responded to the Board's activities, what types of outside information the Board felt should be appended, and how the Board perceived itself.

The Minutes

To analyze the Minutes of the Eugenics Board meetings, I typed out basic information on each meeting (e.g., date, location, number of patients presented, passed, consent stipulations) As well, any themes that I thought were relevant to the activity of the Board were typed out verbatim. After doing this for all the meetings, I printed all this information, organized the pages by decades, and read and re-read them, highlighting "themes" that I thought were important or that seemed to recur. Then, after highlighting, I wrote a word that summarized each theme in the margin. In this way, I could glance at a decade and see which themes were consistently showing up.

Family and Sexual Histories

For the family history and sexual history variables constructed from information in the presentation summaries, I used the same system. In coding this information for the database, I (along with another coder) had to read through the entire case file. We also typed verbatim the family and sexual histories. By the time the string variables were entered into the database, I had already read through the family and sexual histories of my share (about half of the 861 cases) at least twice. In reading and re-reading, and through discussions with the other coders, I had already formulated in my mind some of the themes that seemed to keep appearing.

Once the database was completed, I printed the family, sexual and personality histories (along with sex, diagnosis, reason for sterilization, Eugenics Board number, and date of sterilization). I then read through all of this information (for all 861 cases) highlighting important words or phrases. Since I felt that analyzing the information in this format (about 1000 pages because of the way the information was presented – long but narrow columns) would be too awkward and confusing, I re-typed the family histories, sexual histories, diagnosis, and reason for sterilization, into a "normal" document format (no columns). The result was a much more readable format that took up significantly fewer pages and seemed more manageable. All the family histories for males were in one document, while all the family histories for females were in a separate document. All the male sexual histories were in yet another document and all the female sexual histories were in a fourth document. I typed out the diagnosis and reason for sterilization twice for each case – once with the family history and once with the sexual history. Admittedly this was redundant and inefficient, but I was interested in seeing how diagnosis and reason for sterilization related to each case history – family and sexual. It seemed more convenient to have the diagnosis and reason for sterilization typed out along with the histories, for ready access.

I then separated the pages into units according to decade, and proceeded by reading through the information, drawing boxes around significant phrases, sentences, and words. At the bottom of each page I summarized the themes evident on each page by writing one-word descriptions of the themes (e.g., patriarchy, social class, promiscuity). In this way, when it came time to write the text, I could glance at the bottoms of the pages for easy access to particularly illustrative cases/quotes. At this time I also wrote personal reactions and responses, in addition to questions and many, many exclamation marks in the margins as a way of both venting my shock at some of the writings, but also as a way of marking what I thought were inconsistent and/or irrelevant comments.

Having read through and marked up the copy in this way, when it came time to process the findings, I read through this information yet again, this time keeping track on a yellow "Post-It"™ of the themes (summarized in one word or phrase) evident for each decade. I did this for each variable and for each decade of analysis. In this way, when it came time to compare across decades, I could lay out all my yellow notes on my desk and look at the information as a more complete package. This seemed to make the comparison process more manageable.

When I decided to incorporate the diagnosis and reason for sterilization into the analysis I went back to these original typed-out, scribbled-up, margin-full pages and simply highlighted the diagnoses in blue and the reasons for sterilization in yellow. This was the only color on the pages (other than the purple and blue scribbles), so I could more easily look at the various diagnosis/reason for sterilization combinations for this part of the analysis. As well, since I recorded the diagnosis and reason for sterilization immediately after the family history and sexual history variables, I could see the "package deal" - how the diagnosis and reason for sterilization fit in with the family history or the sexual history.

Although I did analyze the "reason for sterilization" section of the presentation summary, this detailed analysis has been excluded from this study. It has been excluded because it became very clear from the analysis that there was no consistency to the way in which "reasons" for sterilization were assigned, or how they related to family and sexual history and diagnosis. It seems that the "reasons for sterilization" section of the presentation summary was redundant. The mental health professionals identified people they considered feebleminded, a diagnosis was provided, then in the family and sexual histories the patients were constructed as being a "social problem". By the time the patient reached the Eugenics Board, and by the time the "reason for sterilization" was assigned, it had already been decided that the person should be sterilized. At this point the official reasons was irrelevant. Initially the Board said nothing – a "reason for sterilization" was not assigned. Over the years the Board used different reasons. Initially they said "usual reasons", then they quoted directly from the Sexual Sterilization Act (e.g., "multiplication of evil by the transmission of the disability to progeny"), or referred to what was written in the presentation summaries (e.g., family history, sexual history). Sometimes, they referred to the diagnosis (e.g., epilepsy). From the analysis it appeared that there was no formula, no set procedure for assigning the reason for sterilization. I believe it is more useful to focus our attention on the social construction of the patient histories in the sexual and family history sections of the presentation summaries, and suggest that the "reason for sterilization" section does not contribute significantly to our analysis of the social construction of the "problem" of feeblemindedness.

Ethical Issues

There have always been ethical issues regarding the eugenics movement in Alberta. The government and the interest groups in society should have been thinking about ethics in 1928. Perhaps they were, but the Act was passed and people were sterilized, and for this reason there was an out of court settlement in November, 1999. However, research ethical issues remain, for someone trying to reconstruct this story thirty years after eugenics officially ended in Alberta.

First is an issue of anonymity and confidentiality. Although most of the information used in this study is available through the Provincial Archives, and so is public, care has been taken to keep information anonymous. Results are presented in aggregate format and where quotes are taken from the individual case files, the information is presented in such a way that identifying the people who were the victims of the eugenics movement is not possible. The Minutes of the Board meetings are official documents that are also publicly available. Names are used in these documents and also in the analysis. However, since the names are public and since the Board members knew at the time of the meetings that they were acting in a public capacity, they essentially gave their consent for any future analysis that might be conducted on the Minutes. But since individuals presented to the Board were not voluntary participants, their names are not used in the following analysis. As well, Eugenics Board numbers assigned to patients have been changed for the purpose of this analysis. Finally, other information taken from newspapers, speeches, articles and books, also is publicly available.

As was mentioned earlier, there is a moral responsibility to speak for those who cannot or could not speak at the time that this historical event was taking place. They might have spoken, but for the most part their voices were not heard. As such, it is the ethical responsibility of the sociologist-writer in this instance to try and tell this story as best she can. It is her ethical responsibility to do so without harming the people involved, particularly the people who have already been harmed once at the hands of the powerful, educated establishment. I hope that I can do justice to the people involved. I hope that my construction at the very least reveals some of the processes that led to their marginalization.

The PRL project from which the present study emerged received a formal research ethics review. The concerns addressed in this review included the guarantee of anonymity and confidentiality, despite the public nature of most of the data used. As well, there was a concern regarding the public release of any information prior to the trial, and how this would impact the plaintiffs involved. Since the case was settled out of court, this never became an issue.

Finally, I feel it is necessary to comment on the effect of this kind of research on the researcher. It is necessary because, in part, it accounts for the moral stance taken in this thesis and also for my feeling of accountability. It contributes to the need to tell the story in a certain way.

During the 18 months of coding, I was responsible for contributing to the coding of most parts of the database. I coded the minutes. I also coded the case card summaries. As well, I was responsible for coding the administrative forms used by the Board, the institutions, and the surgeons. In other words, I was immersed in most parts of this story. During the initial stages of coding (when I was working primarily alone), I found myself feeling very sad, depressed, like the weight of the world was on my shoulders. I am convinced that what I was doing, and the realization of the extent of what had happened decades before, was contributing to these feelings of malaise. This is not necessarily a negative thing. In fact, I believe that it sensitized me to the story that needed to be told. It made the story of eugenics in Alberta very real and powerful.

Having the other two coders on this project working in the same office helped us all deal with the ethical issues that are bound to affect anyone working on such a project or dealing with such subject matter. The group situation helped offset some of the more tragic stories of abuse and neglect that emerged from the files. In many ways, the project team was as much an emotional support team as an academic support team. The weekly meetings with the supervisor and data analyst helped also to offset the "personal" nature of the material by helping to keep us all grounded. Each week when we got our new assignments or talked about new coding schemes and decisions, it served to distance us from the data. We were regularly reminded that this was a research project. In other words, a balance was maintained between the academic nature of the work and the emotional nature of the work.

At any rate, one cannot read through thousands of pages of such material without being affected by it. In this sense, this thesis is an effort to first and foremost tell the story of the actors in this play. However, it is also an effort to tell a story that has occupied my thoughts for over two years. But, more importantly, it has been the life stories of those involved.

Chapter 5: The "Constructors" and the "Constructees"

There are four basic research questions that need to be answered to gain a better understanding of the eugenics movement in Alberta. These questions have been listed and described in previous chapters. One of the questions concerns the general social milieu at the time of the eugenics movement. In Chapter Two, I provided some of the important historical information regarding the context within which the Eugenics Board started its operations in 1929. Another key question concerns the "who" of the eugenics story. Who was involved? Who was "victimized" or labeled during this period? Who was targeted as the "problem population"? Conversely, who did the labeling? In other words, who were the actors – on both sides of the story?

This chapter attempts to answer these "who" questions. As well, I also look at some of the techniques used by the labelers in constructing this social problem. In other words, I am looking at the "who", and taking a brief look at the "how" as well. The quantitative analyses provided in this chapter are based on the Board Minutes, the basic file and the '1 in 5 sample'. The following chapters use these findings as a starting point and delve deeper into the more subtle meanings conveyed in the Minutes and the "1 in 5" sample.

The Board

In describing the Eugenics Board as a crucial actor in this narrative, we do not have access to the type of information that we have for the patients. For example, nowhere is the race or ethnicity of the Board members and institutional staff members recorded in a systematic manner. We do not know their religious identifications, their ages, or their places of residence. Consequently, I focus on the activities of the Board as a group. This includes the discussions at their meetings, and the policies and procedures that informed their activities. Some mention is made of individual members and their particular activities, when relevant. But for the most part, this description is of the Eugenics Board in action as a group doing its job.

In other studies of the Eugenics Movement in Alberta, the Board has been generally vilified. This was a government-created body that exerted power and control over other Alberta citizens, life-changing control in the form of sexual sterilization. But we can also lose sight of the fact that these individuals believed they were doing 'good'. They were addressing a social problem. They were fulfilling the requirements of a government Act. They were professionals who were cleaning up the province. Moreover, they were 'helping' their clients by making their lives easier. In removing the child–bearing potential of mental defectives and the mentally ill, the Board was preventing these patients from experiencing 'mental injury' as a result of parenthood. At a very basic level, as observers of the Board's activities we need to accept that their actions were not malicious. How could they be? How could educated professionals intentionally inflict such injury on a powerless group of people? This goes against everything we believe (and hope) about the medical and mental health services establishment.

In the following discussion, I examine the Eugenics Board as an organization, focusing on who was involved, how the Board conducted its affairs, and on whether it generally followed its own rules. I first discuss three academic works documenting the activities of the Eugenics Board in its early years. While I could have discussed these studies in the literature review section (Chapter Three), it seemed more appropriate to include them here. They represent part of the social construction of feeblemindedness in that the authors were closely connected to the Eugenics Board. One author, E. J. Kibblewhite, was the Board secretary for many years. The second group of authors is made up of several of the doctors affiliated with the Board. The author of the final article was a graduate student who compiled statistics for the Board on its early activities. As such, these three pieces describe the Board's perspective and its activities. They are part of the social construction of the Board by the Board itself, or more specifically, by the Board's representatives in the academic community.

"Sexual Sterilization: Four Years Experience in Alberta" – by C.A. Baragar, Geo. A. Davidson, W. J. McAlister, D.L. McCullough

This article, published in the *American Journal of Psychiatry* in 1935, offers insight into the mindset of this group of doctors who worked closely with the Board. The article begins by referring to sexual sterilizations in other countries, the numbers and successes of such operations. The authors continue

> with respect to the British Commonwealth of Nations,

> Alberta is the pioneer in legislation of this character, and to the Honorable George Hoadley and a group of active supporters – chiefly organizations of women – must be given the credit for the vision and courage that has placed this statute on the books of the province (1935: 897).

The article introduces the Board members, outlines their roles in the process, and explains who is a likely candidate for sterilization – essentially the technical aspects of the operation of the Board and the enactment of the Act. The article provides ample evidence of the success of the Act, and some of the complaints, although in this respect "with few exceptions there have been no complaints following the operation" (899). Also presented are descriptive statistics regarding education, age, gender, and marital status of patients, whether patients are self-supporting, diagnostic classification, and childbearing records of females, to name a few.

The article addresses what seems to be a primary concern regarding patient behaviour following operation – moral conduct. Although credit is given to institutional training prior to discharge, and to follow-up contacts from social workers, the "facts" seem to indicate that sterilization is successful in this regard. As the authors state: "of one thing we are convinced, sterilization does not lead to increased immorality" (905). Additionally, in two cases, one male and one female, "sterilization has had the effect of keeping together a family that would inevitably have been broken up through separation" (905). And in yet another two cases, sterilization has "certainly prevented further mental breakdowns" (905).

For the authors, mental deficiency is "socially the more serious", compared to mental disease, primarily because frequently arising out of it "are those very grave problems of social maladjustment – moral, antisocial, economic – and of unmarried motherhood and illegitimacy" (906). For mental defectives, who are "unduly prolific both within and without marriage" and who are "prone to pass on to posterity their own defects and to bring into the world children double handicapped by both heritage and early environment", "sterilization is the only rational procedure" (907). Mental health is of utmost importance to the authors of this article, since "it is in many respects a matter of life or death for the race" (908).

Finally, the authors point out that acceptance of sterilization is growing.

> There have been no criticisms of this work in Alberta and it is progressing steadily and smoothly. This is perhaps largely due to the composition of the Board, and to the great care exercised in the selection and preparation of cases, and also to the fact that invariably every effort is made to secure the intelligent cooperation of the patient or responsible guardian (1935: 908).

"Sexual Sterilization in Alberta: Eight Years' Experience, 1929 to May 31, 1937" – by R. R. MacLean and E. J. Kibblewhite

Published in 1937, this rather brief article discusses similar issues. However, because the 1937 amendment to the Act had recently occurred, much of the article is devoted to a discussion of consent issues, and outlines how much easier the sterilization process has become as a result of the amendment. The article discusses several case studies, illustrating the success of the Eugenics Board in decreasing the numbers of mental defectives, and leading to happier lives for the individuals involved. Tables are presented summarizing cases passed and operated on to date. The article concludes with the following statement: "…the work of sterilization in the province of Alberta has been carried on very quietly and efficiently and the results have been pre-eminently satisfactory" (1937: 590).

"Sterilization in Alberta: A Summary of the Cases Presented to the Eugenics Board for the Province of Alberta from 1929 to 1941"- by E. Mary Frost

The third of the earliest pieces of research conducted on the Eugenics Board of Alberta, this is Frost's thesis for a Masters degree in Psychology at the University of Alberta. Frost's name appears often in the Minutes of the meetings of the Eugenics Board, in her role as researcher/ graduate student from the University of Alberta. The report is based on the earliest days of the Board's operation.

Frost was a student of John MacEachran, Chairman of the Board from 1929 until 1965. The thesis is supportive of the Board's work. Frost devotes a section of the report to her own cacogenic studies (tracing 'defectiveness' through family lines), she comments on the "immigration problem", and pleads for more funding for the Board's work. She was writing at a time when the eugenics movement had just received governmental support through the passage of the *Sexual Sterilization Act*.

The Board was "just getting going"; these were the formative years. As well, Frost was present at some of the Board meetings. As statistician for the Board, she had access to the files and played a role in the Board's activities. It would be safe to say that Frost's study contributes to the social construction of the feebleminded problem. Using statistical "proof" as well as scientific techniques for documenting family genetic dysfunction, Frost makes the argument that the Board is needed, is doing a good job, but with more money could be doing an even better job.

The purpose of Frost's study is to provide "a clear and concise summary of the work done by the Eugenics Board for the Province of Alberta" so that if future studies on the topic are done "there will be little or no laborious groundwork to cover before an analysis can be attempted" (29). This thesis appears to be the first attempt at summarizing the activities of the Board in terms of numbers of cases presented, numbers of people sterilized, diagnoses, sex, age, immigration status, and other variables.

Frost makes several criticisms of the *Sexual Sterilization Act* and the eugenics program, stating that "the public might well have expected more to have been done in this field from a positive point of view through present educational facilities and other agencies" (88). She also states that there should be stricter guidelines regarding the terms of Board membership. She suggests that each member should commit to a five-year term and that these terms should be staggered so that "only one member changed in one year" (88). This, she argues, "would not only retain the benefits normally associated with a permanent administrative body of this kind, but would also allow a natural infiltration of new ideas from equally competent persons, and would give to more persons a first hand knowledge of this sociological problem which confronts us today" (88).

Frost also presents an economic argument favoring sterilization and concludes that "apart from the humanitarian side of the picture, which in itself might be considered sufficient to warrant the expenditure of ample funds to ensure the efficient operation of this Act, a brief and purely economic survey is sufficient to demonstrate how penny-saving is false economy in this field" (89).

In terms of immigration, the data from Frost's thesis lead her to conclude that "sufficient evidence is given here of the need for better methods of selecting immigrants so as to eliminate at least those likely to manifest mental weaknesses in the first generation" (91). It is worthwhile to quote directly Frost's last paragraph:

> In conclusion it might be said, firstly, that Alberta has a Sterilization Act, the operation of which has shown itself to be in the best interests of the public both from a eugenic point of view and from an economic point of view; secondly, that there has been a well chosen Board administering this Act in a scientific and intelligent manner; but, thirdly, that the staff entrusted solely with this work has not been sufficiently large to ensure the obtaining of the greatest possible benefit from the operation of the Act (92).

What we have just seen are three examples of the social construction of the Board's activities by representatives of the Board. Let's now turn to some of the other information describing the Board's activities. This information comes from the various data sources discussed in the previous chapter.

Members of the Board and Individuals Present at Meetings

Over the 44 years of its operation, the Eugenics Board had only two Chairmen, Dr. J. M. MacEachran who served from 1929 to1965, and Dr. R. K. Thompson, who chaired the Board from 1965-1972 (Table 1). According to the *Sexual Sterilization Act*, the Board was to be composed of four members, including the Chairman. A total of 19 individuals filled the other three Board positions between 1929 and 1972 (Table 1). In the 1930s and 1940s, there was relatively little turnover among Board members, with the three original members (Pope, Mason, and Field, in addition to the Chairman) each serving approximately two decades. With the exception of Dr. R.K. Thompson who served on the Board from 1950 to 1972, the terms of members appointed in the 1950s and 1960s were typically shorter.

All four members of the Board (including the Chairman) were present for 97% of the 398 meetings it held between 1929 and 1972. Over the decades that the Board was operating, virtually all of the individuals who frequently presented cases to the Board were medical doctors. Two were nurses, two were social workers, and another one simply identified as being from Red Deer. About two-thirds of the approximately 60 other individuals who made presentations at one or two Board

Table 1: Composition of the *Eugenics Board of Alberta*, 1929-1972*

Board Members

Dr. J. M. MacEachran	1929-65
Dr. Edgerton Pope	1929-49
Dr. E. G. Mason	1929-47
J. W. Field	1929-37; 1938-45; 1947-49
Dr. Herber C. Jamieson	1937
Marjorie Pardee	1937
Miss Blanche Emerson	1945
Dr. E. L. Selby	1947-51
R. B. Gunn	1949-56
Dr. A. W. Park	1949
Dr. E. Greene	1949
Dr. R. K. Thompson	1950-72
Dr. W. R. Fraser	1951-64
Mrs. C. T. Armstrong	1956-58; 1962-72
M. Stetson	1958-60
Dr. Margaret Thompson	1960-62
Dr. A. V. Follett	1964-1972
H. E. Panabaker	1966-67
Dr. W. R. N. Blair	1967-68
Dr. D. Gibson	1968-69
Mr. E. J. Kibblewhite	1969-72

Chairmen of the Eugenics Board

Dr. J. M. MacEachran	1929-65
Dr. R. K. Thompson	1965-72

*Source: Minutes of the Eugenics Board.

meetings were also medical doctors. If we equate education and occupational status with the power to label, then the aforementioned people should be considered "powerful" people.

In addition to Board members and "presenters", other professionals (e.g., nurses, surgeons, social workers) or support staff (e.g., secretaries), and sometimes other visitors, might sit in on Board meetings. Attendance at the Board meetings ranged from a low of four to a high of 15 people over the years. Including Board members, "presenters" and others, for all 398 official Board meetings, an average of 8.4 people were present.

Length of Meetings and Number of Cases Considered

The Eugenics Board held the most meetings (123) in the 1960s, while the fewest (58) were held in the 1940s (Table 2).[1] When it met, the Board typically examined a set of new cases, but it sometimes also returned to a discussion of previous cases or had some cases re-presented (particularly after 1937, when the *Sexual Sterilization Act* was amended). The average number of cases (new, previous, and re-presented) considered per meeting was considerably higher in the 1930s and 1940s (averages of 16 and 21 cases, respectively) compared to later decades.

Using new, previous, and re-presented cases in our calculations, we estimate that, across the decades, the Board spent about 13 minutes considering each case.[2] In its first decade of operation, the Board averaged about 15 minutes per case. By the 1940s, the average time spent per case had declined considerably, to about 8 minutes per case. But by the 1960s and 1970s, the Board averaged 16 and 17 minutes per case, respectively. Likely this had to do with the fact that IQ tests were used more extensively during this time period, and it took more time to look over the results of such tests. With the exception of this last observation, it appears that the Board spent the most time per case in its earliest years of operation.

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[1] Since the Board disbanded in 1972, comparison to this decade are inappropriate.

[2] This is clearly an overestimate since, in two-thirds of its meetings (63%), the Board also spent time discussing more general issues and examining correspondence, in addition to the routine review of the Board's agenda, the signing of forms, and the consideration of Minutes of previous meetings. With respect to the latter, the Minutes of the previous meeting were approved in 376 meetings, and read and

Table 2: Location of Eugenics Board Meetings and Average Number of Cases Considered per Meeting, 1929-72.

	Number of Eugenics Board Meetings					
Location	1929-39	1940-49	1950-59	1960-69	1970-72	Total
Alberta Hospital (Ponoka)	46 (29)[1]	48 (24)	52 (10)	27 (4)	3 (2)	176 (18)
Provincial Training School (Red Deer)	18 (6)	8 (9)	37 (9)	40 (12)	8 (10)	111 (9)
Alberta Hospital (Oliver)	1 (9)	1 (3)	9 (20)	39 (9)	8 (7)	58 (11)
Deerhome (Red Deer)	0	0	0	17 (7)	1 (4)	18 (7)
University Hospital (Edmonton)	16 (4)	0	0	0	0	16 (4)
Other locations	18 (3)	1 (1)	0	0	0	19 (3)
Total	99 (16)	58 (21)	98 (10)	123 (9)	20 (7)	398 (13)

Source: Minutes of the Eugenics Board of Alberta.

[1] Average number of cases per meeting (new cases, previous cases, and cases re-presented).

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corrected in two meetings. For 20 meetings, there is no mention of the Minutes of the previous meeting being considered (this would, of course, not be possible for the first meeting of the Board).

The Institutions

The province's mental health institutions, or the "presenting institutions" were responsible for selecting who it was that would be brought to the attention of the Eugenics Board. They played an important role in this process since they were often one of the first contacts these people had with the mental health system. The staff in these institutions were responsible for "constructing" the lives of individuals in the presentation summaries in a way that would "make the case" for their sterilization. Along with the Board they had a very important role to play. Some of their activities therefore, must be discussed. For example, how did institutional staff construct the lives of patients? Are there patterns or techniques that appear repeatedly within the presentation summaries?

For now, we turn to a description of the populations who were targeted by the movement. Following this, we discuss the means through which the Board and the institutions constructed the problem of feeblemindedness – the methods of control they used, and the tools that aided them in constructing this "problem".

Presentation to the Board meant approval for sterilization.

Table 3 illustrates that of all cases ever presented to the Board (4785), 99% were passed. In other words, only 1% of people who appeared before the Board were not approved for sterilization. Of course this does not mean that 99% of the people presented to the Board were sterilized. However, what this number tells us is that the Board believed that 99% of the people it saw "required" sterilization. The 1% who escaped approval for sterilization were "deferred" cases. They were generally deferred because they did not fall within the scope of the *Sterilization Act* or because the Board wanted additional information. In short, the Board never said "no".

About 40% of cases presented were not sterilized. This percentage cannot be attributed to the decision-making processes of the Board since it considered only 1% 'unworthy' of sterilization. In other words, once a patient was presented, it was almost a foregone conclusion that a decision to sterilize would be made. However, once passed for sterilization, some other processes resulted in 40% being spared. What were these processes? Who was more likely to escape treatment? Who was

Table 3: Cases Passed and Decisions Deferred by Gender by Decade, 1929-1972.

	Cases Deferred*						
Decade	Female	Male	Total	Cases Passed	Total Cases	Cases Passed as % of all Cases	Deferrals as a % of all cases
1929-39	6	3	9	1461	1470	99.4%	0.6%
1940-49	6	7	13	1117	1130	98.9%	1.2%
1950-59	5	1	6	988	994	99.4%	0.6%
1960-69	8	9	17	1023	1040	98.4%	1.6%
1970-72	1	0	1	150	151	99.3%	0.7%
Total	**26**	**20**	**46**	**4739**	**4785**	**99.0%**	**1.0%**

* A larger number of cases (60 in total) were deferred at one point. However, some were subsequently re-presented and passed. Only 46 cases out of the total of 4785 presented to the Board remained as deferrals.

Source: Minutes of the Eugenics Board.

least likely? These are the types of descriptive questions that are addressed in this section.

Gender

> "We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt as such by those concerned, in order to prevent our being swamped with incompetence....The principle that sustains compulsory vaccination is broad enough to cover cutting the fallopian tubes." (Justice Holmes, *Buck v. Bell*, 1927)

Gender Differences in Presentations

The eugenics issue is a gender issue. The database compiled for this study shows that beginning in the 1940s, women were more likely than men to be presented, even though women made up less than 40% of all patients in the "feeder institutions"[3]. In other words, being a woman in an Alberta mental health institution meant a greater probability of being presented for sterilization to the Eugenics Board. For all four "feeder institutions" across all decades of operation of the Eugenics Board, the probability of being presented if you were a female was 0.048. If you were a male, the probability was 0.024. Presentation to the Board was a gender issue[4].

Gender Differences in Sterilizations

Sterilization was also a gender issue. Sixty-four percent of all women presented to the Eugenics Board were sterilized. Fifty-four percent of men presented were sterilized. In terms of overall sterilization percentages, 58% of all the people sterilized under the direction of the Eugenics Board were women. With the exception of 1937, 1947, 1954-55, 1957-58, 1961, more women than men were sterilized, even in the 1930s when men were more likely to be presented to the Board. In each decade, more women than men were sterilized. Table 4 illustrates some of these differences.

To summarize, we have so far demonstrated that more women than men were presented to the Eugenics Board as candidates for sterilization, and that more women

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[3] Men were more likely to be presented in the 1930s, but this changed in the 1940s and on.

[4] These probabilities are based on calculations using Canadian Census data and information from the provincial Public Health Reports (Alberta Public Health Reports 1921-1971). These Reports recorded annually the numbers of people institutionalized in the province's mental health institutions.

Table 4: "Sterilizations" by Gender, 1929-1972.[1]

Year	Male	Female	Total
1929-1933	48	158	206
1934-1938	198	240	438
1939-1943	122	151	273
1944-1948	88	124	212
1949-1953	84	162	246
1954-1958	208	160	368
1959-1963	178	276	454
1964	37	44	81
1965	45	47	92
1966	42	65	107
1967	34	63	97
1968	29	40	69
1969	25	38	63
1970	22	41	63
1971	22	33	55
1972	1	9	10
Total	1183	1651	2834

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[1] Numbers in this table are from the Basic data file.

were ultimately sterilized, even though the Alberta population (and the main "feeder institutions") contained more men than women over the years the Board was operating. Thus, the higher rates of sterilization for women can be traced to decision-making processes within the provincial mental health system. The main "feeder institutions" were more likely to present their female patients to the Board. Why were they doing this?

One can speculate that many factors played a role in this process. The feeling generally in society at the time was that women were more of a eugenic threat than men. Maybe the institutions were responding to this general ill will toward 'defective' women. Perhaps women were the primary institutional workers (e.g., social workers) and because they would have likely been middle class professionals, they might have been 'harder' on their female patient counterparts. If women were the primary moral entrepreneurs when it came to the domain of family (child bearers, caregivers, upholders of family values), and historical accounts indicate they were (cult of domesticity, cult of womanhood), then they would be particularly diligent in their job of 'cleaning' up the defective problem and cleaning up the institutions. This might explain the 'tougher' approach with women. Alternately, it was likely the case that the superintendents, doctors, and psychiatrists at the time were primarily men. The focus on women might from this perspective be an example of male professionals dealing with "defective women". It may also have been a combination of the two processes. These issues are discussed in more detail below. For now, the discussion turns to a description of the other social groups who are over-represented in presentations to the Eugenics Board and also in sterilizations.

Is there any evidence that other social groups (e.g., the young, immigrants, ethnic or religious minorities) were more likely to be presented to the Eugenics Board? While we cannot examine the over- or under- representation of such groups in the main "feeder institutions" as we did for women and men,[5] we can, for some groups, compare their distribution in the larger Alberta population with their distribution in the '1 in 5' sample of cases presented to the Eugenics Board. If we find, for example, that aboriginal Albertans were more likely to be presented to the Board, it might mean that they were more likely to be institutionalized in the four main "feeder institutions". Alternatively, it might mean that, once in such institutions, they were more likely to be brought in front of the Board by institutional officials. Perhaps both processes were operating. Whatever the explanation, evidence that such a group was over-represented among cases presented to the Eugenics Board would be evidence that the system, as a whole, discriminated against members of this group.

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[5] Such information is not available in the annual Public Health reports that we used to obtain the numbers needed to calculate the gender distribution of patients in each of the four institutions.

Being Young Meant Greater Chances of Being Presented and Sterilized.

> "In reply to a question put to the Board by Dr. le Vann, the Board gave it as its considered opinion that it is preferable to wait with presenting cases until they reach adolescence. This is because of the fact that it is felt that the sexual tendencies of those presented may be better evaluated at that time. In cases where the trainee is to be discharged, the Board is of the opinion that these could be presented before discharge" (Eugenics Board meeting minutes, February 9, 1951).

Using information on birth dates or age in the '1 in 5' sample database, we were able to calculate the "age at (first) presentation" and "age at sterilization" (if sterilization occurred) for all but four of the 861 cases.[6]

Presentations

Teenagers and young adults made up less than 20% of the provincial population[7], but they accounted for 44% of all cases presented and 55% of all cases sterilized. About 12% of the cases presented to the Board were children under the age of fifteen. Twenty-seven percent were teenagers between the ages of 15 and 19; 17% were young adults between the ages of 20 and 24. The remaining 44% were people 25 years and older.

Comparisons to Census data for the province of Alberta between the years 1921 and 1971 reveal some interesting findings. While a considerable number of children were presented to the Board, they were under-represented relative to other age groups. Older Albertans (40 years and older) were also under-represented.

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[6] If the actual day and/or month of an individual's birth was not reported, we estimated their age when presented (or sterilized) by using "15" as the day of birth and "6" as the month of birth.

[7] This information was calculated from Canadian Census data. Any further statistics regarding the Alberta population come from the same source.

Groups over-represented in terms of presentation to the Board include the 15-19 age group and the 20-24 age group. Individuals age 25 to 29, 30 to 34, and 35 to 39 were also over-represented among cases presented to the Board, but not to the same extent as were teenagers and young adults. Thus, the Eugenics Board clearly focused it energy on the portion of the population most likely to be having children. But is also acted proactively, in that 12% of the cases it considered involved children under the age of 15.

Among females presented to the Board, a much higher proportion were children (15% of female presentations involved individuals under age 15, compared to only 7% of male presentations). Gender differences for the other age categories are not large, with one exception. While 9% of the men presented to the Board were 40 years of age and older, only 2% of the women presented were this old. Again, this is related to the child-bearing issue. Women in this age group are less likely to get pregnant, however men in this age group can still father children.

Sterilizations

The age distribution of the 524 people in the '1 in 5' sample who were eventually sterilized (61% of the 857 individuals whose age could be determined), indicates that children under 15 years of age made up about 13% of sterilizations. This same group makes up 12% of cases presented to the Board. Teenagers, who made up 27% of presentations, made up 38% of sterilizations. Young adults between the ages of 20 and 24 made up the same proportion of cases sterilized as presented (17%). In other words, of all the age groups, teenagers were more likely to be sterilized after appearing before the Board. About 94% of the children "passed" by the Eugenics Board were eventually sterilized, along with 83% of the teenagers.

The main reason for these differences in rates of sterilization for children and teenagers (compared to adults), was that almost all (93%) the children (individuals under age 15) presented to the Board were diagnosed as "mentally defective," along with four out of five (82%) of the teenagers (age 15 to 19). By constructing the younger patients as "mentally defective", the need for parental consent was eliminated. Sterilization could proceed without any objection. People just entering their child bearing years and years of sexual experimentation would be effectively prevented from reproducing. As a result of the Amendment to the *Sexual Sterilization Act* in 1937, which eliminated the need for consent if the patient was diagnosed as "mentally defective", constructing younger patients as defective served to increase the efficiency of the Eugenics Board. After this date, and especially in the 1950s and 1960s, younger people were sterilized at a higher rate than other age groups.

This change in age of patients presented likely has to do with the changing activities of the "feeder institutions". In 1929, when the Eugenics Board began its operations, and for about twenty years after that, Alberta Hospital in Ponoka was the primary source of patients. Alberta Hospital is a mental hospital whose clientele were primarily mentally ill people so it is likely that patients were generally adults. In the 1950s, the Provincial Training School (PTS) began to be more active. By the 1960s, Deerhome also became a primary presenting institutions. Both of these latter institutions had as patients primarily children and adolescents who were receiving educational, life skills, or vocational training. Many were incapable of living outside of the institutions and many had been diagnosed as "mentally defective". So part of the age changes in presentation is a function of changing activity on the part of mental health institutions.

Urban-Rural And Immigrant-Non-Immigrant Differences

Most of the "presentation summary" sheets in the '1 in 5' sample files indicated where patients were living prior to being institutionalized and/or presented to the Eugenics Board. These sheets also listed the patient's place of birth. This information was used to categorize cases as rural or urban, and as immigrant or native-born.

Presentations

Information on where patients had been living was available for 746 cases (87% of the total). A three category "urban-rural" variable was constructed by labeling Edmonton and Calgary as large cities, and communities like Lethbridge, Red Deer and Medicine Hat as small cities. Individuals who came from smaller communities or rural areas were placed in the "small town/rural" category.[8] The '1 in

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[8] A small number of patients' home address identified communities in neighboring provinces. These communities were coded in the same manner.

5' sample results suggest that across the decades that the Board was operating, 56% of all the individuals brought before it were of rural/small town origin, while 35% were from Edmonton or Calgary. During the 1940s and 1950s, a somewhat higher proportion of small/town rural individuals was presented to the Board. However, comparing Census results to the '1 in 5' sample data, it is apparent that, up until the late 1960s, rural/small town residents of the province were under-represented among individuals presented to the Board. Instead, residents of larger urban centres were somewhat more likely to be presented.[9]

Data on immigration status also exists for the '1 in 5' sample (place of birth was not recorded for only 2% of the cases). Four out of five (81%) of the individuals presented to the Board between 1929 and 1972 were born in Canada. However, this proportion varied by decade. During the 1930s, only 60% of the cases presented were individuals born in Canada. By the 1940s, this figure had risen to 80%, and by the early 1970s virtually all the individuals being presented were born in Canada.

Comparisons to Census data for the various decades reveal that in the 1930s, the proportion of individuals presented to the Board who were immigrants was almost identical to the proportion of immigrants in the total population. By the 1940s, immigrants were under-represented among cases presented to the Board, and this pattern became more pronounced in the later years of the Board's operations. Thus, there is no evidence that immigrants were more likely to be presented to the Eugenics Board, compared to native-born Canadians. In fact, the opposite appears to have been the case[10].

Sterilizations

Overall, presented individuals living in cities (before being institutionalized and/or presented to the Board) were somewhat more likely to eventually be sterilized (probabilities of 0.65 and 0.63), compared to rural residents of the province presented to the Board, only 55% of whom were ultimately sterilized.

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[9] Census data for the province in each census year were grouped to obtain direct comparability to the data, that is, the total population was separated into three categories: Edmonton/Calgary; smaller cities; and small towns/rural areas.

[10] Timothy Christian (1974) reported that the number of East European immigrants presented and passed for sterilization by the Eugenics Board was disproportionately high when compared with the ethnic composition of the Alberta population.

Ethnicity and Religion

"Catholics, Prussians,
The Jews and the Russians
All are a curse
Or something worse…."

(quote from a poem sent to Hitler by British sterilization advocate Marie Stopes; 1939; from Paul, 1995: 95)

The "presentation summary" sheet for each of the cases in the '1 in 5' sample file typically contained information on the ethnicity and the religion of the individuals being presented to the Eugenics Board. Information on ethnicity was available for 92% of the 861 cases, while information on religion was available for 96% of the cases. This information was grouped into nine categories for ethnicity, and into five categories for religion as outlined in Box 1 below.

Almost one-third (31%) of the individuals presented to the Eugenics Board were of Anglo-Saxon background, 8% were of German origin, another 10% were of other western European backgrounds, and 11% were simply identified as "Canadian" (or "American"). These figures shifted to some extent over the decades (e.g., the proportion listed as "Canadian" grew), but the overall pattern remained much the same. Eastern Europeans constituted 19% of the total over the years (dropping from 22% in the 1930s to 16% by the 1970s). While only a small number of cases of Aboriginal origin were presented to the Board in the 1930s, the figure had risen to 7% by the 1950s and 1960s. The total number of cases presented in the 1970s is small (n=30), and so statistics from this period must be used with caution, but it is noteworthy that 8 of these individuals (27%) were of Aboriginal origin.

As with previous analyses, comparisons were made with Census data for selected years between 1926 and 1971 to examine ethnicity patterns in the province of Alberta during the decades that the Eugenics Board was operating. Even if we include all of the individuals presented to the Board as "Canadians" with those of Anglo-Saxon origin, we still must conclude that this group was under-represented among Eugenics Board cases up until the 1950s. This pattern changed in the 1960s. Individuals of German origin, and others with western European backgrounds, were also somewhat under-represented among cases appearing before the Eugenics Board.

Box 1: Categorizing Ethnicity and Religion

Ethnicity

(1) Canadian – identified as "Canadian" or "American"
(2) French – from either Quebec of France (they could not be distinguished from each other, given the information available)
(3) Aboriginal – identified as Indians, Metis, "half-breed", "part Indian", "treaty", or Eskimo
(4) Anglo-Saxon – British, Anglo-Saxon, English, Irish, Scottish, or Welsh (including two individuals identified as "Caucasian"
(5) West European – Dutch, Austrian, Swiss, Swedish, Belgian, Finnish, Norwegian, Italian
(6) Central European – Ukrainian, Polish, Russian, Czechoslovakian, Romanian, Hungarian, Bohemian
(7) German – identified as German, including Mennonites
(8) Other – a very small number identified as Negro, Chinese, Japanese, Jewish, or Hebrew
(9) Unknown – ethnicity listed as "not known" or a question mark

Religion

(1) Mainstream Protestant – identified generally as "protestant," or specifically as United Church, Anglican, Lutheran, Baptist, Presbyterian, or Methodist
(2) Other Protestant – including Pentecostal, Evangelical, Mennonite, Mormon, Christian Reformed, Church of God, Swedish Mission, Salvation Army, and Brethren
(3) Catholic – Roman Catholic, Greek Catholic, Ukrainian Catholic
(4) Other – Seventh Day Adventist, Jehovah Witness, Hebrew, Buddhist, Confucian, Doukhobor
(5) Unknown – includes several cases of "no religion" and "agnostic"

In contrast, two groups tended to be over-represented among cases presented to the Board. With the exception of the 1930s, when the Aboriginal proportion of the provincial population was similar to the proportion of cases presented, Aboriginals and people of Eastern European background were over-represented in presentations. The available data do not allow us to determine whether eastern Europeans and Aboriginals were more likely to be institutionalized in the main "feeder institutions", whether they were more likely to be presented to the Board once in such institutions, or whether both processes were operating. Nevertheless, it is clear that the overall mental health system supporting the Eugenics Board, and providing it with cases, appeared to be systematically discriminating against these two groups.

Turning our attention from ethnicity to religion, we find that, based on the '1 in 5 sample', 55% of the individuals presented to the Eugenics Board were in the "mainstream Protestant" category, 33% were Catholics (of various denominations), 7% fit into the "other Protestant" category, and 4% were either identified as having no religion or this information was not provided. These proportions varied somewhat over the decades, but not enough to change the basic pattern.

Using comparisons with Census data over the decades there is evidence that, at least up to the early 1960s, mainstream Protestants were under-represented among individuals presented to the Eugenics Board. "Other Protestants" were also somewhat less likely to appear before the Board. In contrast, while Catholics made up between 23% and 27% of the provincial population between 1921 and 1971, they represented between 29% and 47% of the cases presented to the Board over the decades it was operating. Since a larger proportion of East Europeans (and probably individuals of Aboriginal origin) would likely have been identified as Catholics (of one type or another), the ethnicity and religion biases of the mental health system that supported the Eugenics Board are probably inter-related.

The probability of eventually being sterilized after being "passed" by the Board was the highest for the Aboriginal group of cases in the '1 in 5' sample. Three out of four (74%) were eventually sterilized. East and west Europeans, the two groups with the highest percentage of "patient consent" decisions made by the Board, were least likely to be sterilized (probabilities of 0.47 for both groups). Catholics and "other" Protestants were least likely to eventually be sterilized, in part because larger proportions of these two groups received a "patient consent required" decision when the Board examined their cases.

Social Class Differences

It would be interesting to compare rates of presentation and sterilization for lower class and middle class individuals. We expect that individuals from a more advantaged background fared better in the mental health system that supported the operations of the Eugenics Board. Unfortunately, the information contained in the '1 in 5' sample files is not sufficient for the task. Information on patient's family income, occupations (parent and/or patient), employment history, and educational attainment was not available for a majority of patients.

Implementing the "Tools" of Social Control

We have discussed the people who were 'targeted' by the institutions and the Board. We have also discussed some of the activities of the agencies of control: the Board and the Institutions. But one piece of the story is missing. How did these agencies exert control over the target population? What tactics and techniques did they use? We know that the ultimate "technique of control" was sexual sterilization. However, there were steps leading up to sterilization where this ultimate disposition could have been averted. There were resources to which the institutions had access - medical, social, and legal resources – which they used to help 'make the case' for sterilization. Each of the resources was used to 'prove' that sterilization was necessary; each of the resources helped bring the patients one step closer to the operating table. At each of these stages, the medical or legal establishment's techniques for determining eligibility for sterilization alternately could conclude that sterilization was unwarranted, thus sparing the patient's reproductive capacity. However, as we have seen, the Board never said "no."

For example, the consent issue was a crucial mechanism for many people; it could mean the difference between having children or not. In other words this was one of the legal avenues available to the Board, and to patients. The Board and institutions also used psychiatric evaluations and IQ testing as a means for determining eligibility for sterilization, in addition to the necessity for patient consent. The institutions also compiled information on patient sexual and family history in the presentation summaries. The presentation summaries also documented "prospects for discharge" (is the patient capable of life on the 'outside'?), as well as the assigned "reason for sterilization". These forms of control are discussed in this section. A more detailed discussion of the sexual histories, family histories, diagnosis and reason for sterilization is covered a later chapter.

Consent

> "My father never remembered signing anything, but he always blamed himself for what happened. He died without grandchildren." (Wayne Ruston, Plaintiff, Alberta Report, March 30, 1998).

As we discuss in more detail below, consent was a key issue for the Alberta Eugenics Board. In its formative meetings, patient consent was discussed extensively. The Board was very concerned with attaining consent and attaining it through proper channels. After 1937, when the Act was amended, once a patient was diagnosed as "mentally defective", consent was not necessary. Furthermore, if patient consent was not a requirement, sterilization eventually took place in the vast majority of cases. Across all decades, for both sexes, if consent was not mentioned, the probability of a patient being sterilized was 0.89. If patient consent was required, this probability dropped to 0.15.

"Patient Consent" Requirements for Sterilization

We have seen that 40% of patients "passed" by the Eugenics Board never were sterilized. Furthermore, for a considerable number of those who were sterilized, their operation took place long after they were "presented and passed". Why? If "patient consent" (or the consent of a parent/spouse/guardian) was a requirement, an individual (or her/his parent/spouse/guardian) could obviously withhold consent and so delay an operation indefinitely. If "patient consent" was not made a condition for sterilization to occur, the process of expediting the recommendations of the "feeder institution" and the Board's decision would be much smoother.

The official Minutes of the Eugenics Board meetings were systematically examined and any evidence of consent requirements attached to the Board's decision to sterilize a particular individual was recorded. Five different categories of "consent requirements", including "consent not mentioned" were then created. Over the years, a number of different conventions were followed in recording consent requirements (or in not doing so), so a brief outline of the content of our coding categories is useful (Box 2).

Differences by Decade and Gender

For the total population of cases presented (all decades, female and male cases, deferrals excluded), "consent not mentioned" is the largest category (54%), followed by "consent of patient required" (30%), "consent of patient and other(s) required" (10%), and "consent of other(s) required" (5%).

Across all decades, patient consent was required for 42% of the female cases presented and passed, along with 39% of the male cases. However, this pattern changed considerably across decades. In the 1930s, patient consent was required in 41% of the female cases but a considerably higher proportion of male cases (54%). In the 1940s, despite the fact that the 1937 amendment to the *Sexual Sterilization Act* made obtaining consent unnecessary for patients considered to be "mentally defective", the proportion of cases in which patient consent was required rose to 61% for women and 65% for men. However, these proportions dropped dramatically over the next decades, from 38% in the 1950s to 18% in the 1970s for female cases, and from 18% to 5% for male cases.

Across all decades the probability of sterilization was higher for women, for each consent condition. For example, if patient consent was required, only 9% of males presented to the Board were ultimately sterilized, compared to 21% of females[11]. If consent of the patient was required, for women the probability of sterilization was higher in the 1950s (0. 25), and particularly so in the 1960s (0.46) and 1970s (0.31). For men, if consent was required, the probability of sterilization rose from about 0.09 in the 1930s, 1940s and 1950s, to 0.18 in the 1960s.

The mental health institutions and the Board constructed the problem of feeblemindedness in such a way that many of the patients were seen as being

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[11] While it is impossible to determine from the information sources available, it may be that it was easier for the Board, and the institutions presenting cases to the Board, to convince women to agree to being sterilized.

Box 2: *Categories of "consent requirements"*

(1) Consent not mentioned

- nothing stated at all (rarely the case after December, 1938)
- "passed clear" – no indication of any conditions (appearing after October, 1938)
- "passed clear" and patient identified as "mentally defective"

(2) Patient consent required

- subject to the consent of patient
- "passed clear" with consent of patient provided

(3) Consent of patient and other(s) required

- others might include a spouse, parent, guardian, or the Minister

(4) Consent of other(s) required

- might include a spouse, parent, guardian, the Minister, or the Indian Affairs department

(5) Other conditions

- specific physical, neurological, or intelligence tests required
- other conditions (e.g., further observation of the patient for set of period of time)

incapable of controlling their own lives. They were constructed as being "too mentally defective" to make decisions regarding their future. By initiating the Amendment in 1937 which made it possible to sterilize a mental defective without his or her consent, the Board essentially gave itself the power to construct people as mentally defective and in so doing revoke any right they had to determine their own future. As a tool for the construction of the problem, patient consent was powerful, so powerful that it alone was responsible for the sterilization of hundreds of people. Once defined as mentally defective, they had no recourse to undo the Board's construction of them as "worthy" of sterilization – without consent.

Psychiatric Evaluations and IQ Testing

> The Eugenics Board requested "that a Psychologist attend the Eugenics Board meetings for the purpose of interpreting the various Psychological Test results for the Board." These tests had been in use since 1929 (Eugenics Board Minutes, November 27, 1958).

In the following analyses that examine the extent to which psychiatric evaluations and IQ testing played a part in Eugenics Board decision making, we must rely on data in the '1 in 5' sample since such information is no longer available for the complete population of presented cases. However, because the '1 in 5' sample is a representative cross-section of the total population of cases, conclusions based on this sample can be generalized to the larger population of all cases presented to the Eugenics Board.

Psychiatric Diagnoses

"Diagnoses" was recorded in two locations within the '1 in 5' case files: on the presentation summary and on an "official" Public Health form. We use the diagnosis listed on the latter because of its official status, but also because it is likely that such information was transferred from the official form to the presentation summary. This information is missing for 42 (5%) of the 861 cases in the sample.[12]

After recording this information in the PRL database, we collapsed the many different diagnoses recorded into three main categories: psychotic, mentally defective, other.[13] A "mentally defective"/ "mentally deficient" diagnosis (alone or in combination with something else) accounted for 55% of all 861 cases in the '1 in 5' sample. Forty percent of all cases (348 in total) were simply diagnosed as "mentally defective" or "mentally deficient". Almost four out of ten cases (39%) fall into the "psychotic" category, with schizophrenic diagnoses accounting for most of these cases. Following the lead of the Eugenics Board in categorizing epilepsy as a "psychosis", we observe a total of 27 cases where epilepsy was the primary diagnosis and an additional 46 cases where this information was included along with a diagnosis of "mentally defective".

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[12] In 32 of these 42 cases, the document itself was missing from the files. In the remaining 10 cases, the diagnosis was not recorded on the form.

It is interesting to note that only one diagnosis of "average intelligence" was recorded. However, 27 cases were diagnosed as either "borderline intelligence", "moderately mentally defective", or "moderate mental retardation", subcategories within the "mentally defective" category.

Diagnoses of "mentally defective" were somewhat more common for male patients presented to the Board (60% compared to 51% for females). "Mentally defective" diagnoses were much more likely to be provided for younger patients presented to the Board. For example, 93% of those under age 15 when presented had such a diagnosis listed for them, along with 82% of those age 15 to 19. The lowest likelihood of having such a diagnosis (around 30%) was observed for patients ages 25 to 39. However, a majority (60%) of older individuals presented to the Board (age 40 and older) were also described as "mentally defective" on the official form provided to the Eugenics Board when it was considering their cases.

IQ Testing

An examination of the "presentation summary" sheets prepared for each of the 861 cases in the '1 in 5' sample reveals that no information was recorded regarding IQ testing for 299 of the cases (35% of the total). It is possible, of course, that IQ tests had been performed for some of these individuals. However, since the "presentation summary" sheets constituted the primary source of information available to Board members when they made a decision, we can conclude that such decisions were made in the absence of IQ information for about one-third of the cases considered.

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[13] Our basic coding scheme was modeled on reporting categories used in Eugenics Board reports.

IQ testing was relatively uncommon for patients diagnosed as "psychotic" – no IQ information was recorded for 67% of the 338 cases of this type in the '1 in 5' sample. In contrast, at least one IQ test score was reported for 44% of the 474 '1 in 5' cases diagnosed as "mentally defective", two IQ test results were reported for 28%, and three or more were reported for 17% of these cases. As the decades progressed, IQ test results were more often reported on the presentation summaries. In fact, by the 1950s, the Board received information on two or more IQ tests for one-third of the cases it examined. By the 1960s, this figure had risen to 53%, and in the 1970s it was 83%.

However, it is noteworthy that no IQ test results were reported for 11% (53 cases) of the individuals in the '1 in 5' sample diagnosed as "mentally defective". Since the '1 in 5' sample is a representative cross-section of the complete population of cases presented to the Eugenics Board, we can estimate that, over the years, approximately 265 individuals presented to the Board as "mentally defective" were presented without any IQ test results to verify such a diagnosis.

Gender differences are of little consequence, that is, IQ test information was more or less equally likely to be part of the "presentation summary" sheet for women and men. However, it is very apparent that IQ test results were much more likely to be used when young patients were brought before the Board. No IQ information was recorded for only 6% of the patients age 0 to 14, and only 13% of those between 15 and 19 years of age. However, IQ test information was not available for over half of the patients age 30 and older.

IQ Test Results and Variance in IQ Scores

There is evidence that the "mentally defective" status of people passed by the Board for sterilization is questionable. Almost one in ten (9%; 36 cases in the 1 in 5 sample) of the individuals diagnosed as "mentally defective" when presented to the Board had overall IQ scores of 70 or higher. Furthermore, in 27% of these cases, the variance between the highest and lowest overall IQ score for an individual was between 10 and 19 points, and in an additional 7% of cases, the variance was even larger, ranging from 20 to 33 points. Thus, for at least a third of the "mentally defective" cases, the recorded information suggests that the IQ test results being examined by the Eugenics Board were rather variable or, in other words, not very reliable. This did not appear to affect the Board's decision making, however, since it still "passed" 99% of the cases that it considered.

In other words, without getting into the minutiae of the IQ test results, there is some evidence that IQ testing, as a "tool" of social control used by the Eugenics Board, was fallible. It was used to provide scientific/ medical "evidence" for the sterilization of patients. However, we see from the analysis that people labeled as mentally defective often had not been tested. Sometimes, when they were tested their scores were close to the "normal" range. Finally, for those who had multiple tests, there was quite a range between scores on the various tests. But who would question something so "scientific" and "accurate" as an IQ test?

Prospects for Discharge

The 1928 *Sexual Sterilization Act* stated that sterilization would be appropriate if the Board was of the opinion "that the patient might safely be discharged if the danger of procreation with it attendant risk of multiplication of the evil by transmission of the disability to progeny were eliminated…". The goal was to sterilize primarily those who might someday be released from durance. If a possibility of eventual discharge existed, one would expect that the Eugenics Board would have considered this information in its deliberations about each case.

The "presentation summary" sheets in each of the files in the '1 in 5' sample did not contain a specific sub-category of information dealing with "prospects for discharge". However, comments about the possibility of discharge, or the inevitability of permanent institutionalization, can be found in various locations on the "presentation summary" sheet in a minority of the files. After examining each of the 861 files in the '1 in 5' sub-sample, we developed a simple six-category "prospects for discharge" classification scheme.

In three out of four files in the '1 in 5' sub-sample (630 cases, or 73%), no information about the prospects of discharge of the patient could be located in the "presentation summary" sheets. A total of ten files (1%) contained information suggesting that the patient would be discharged once the sterilization operation took place. (e.g., "since admission he has shown considerably improvement and it is thought that he is about ready for discharge". EB#2152[14]). In a larger number of cases (49 cases, or 6%), it was apparent that the individual had been admitted (or brought to) the institution, or re-admitted, primarily so that the sterilization operation could be performed, the expectation being that the individual would return to the community after the operation had taken place. An example would be EB#3995, in whose file the following comment appears: "She was discharged to the care of her husband May 29, 1962. She is returning June 2 1962 as an outpatient for presentation to the Eugenics Board." In another 30 cases (3% of the total), one could infer that such a process (i.e., admission or re-admission so that sterilization could take place) was occurring, although it was not clearly stated.

In 91 of the files (11%), the information recorded suggested that, in time, perhaps with further training, the patient could be discharged. For example, one individual (EB#1075) was described in the following manner: "Would be very useful at home but not worth wages outside the home. With training, she may, in time, be worth her keep but not worth wages." However, in 51 cases (6% of the total), it was clear that the institution presenting the individual to the Board was quite convinced that the patient would never be discharged. For example, one patient's (EB#3359) prospects for discharge were described as follows: "Because of [patient's name] limited ability and recent deterioration due to his epilepsy, it is doubtful if he will ever be dischargeable."

Since the 1928 *Sexual Sterilization Act* did make explicit reference to the issue of a patient being safely discharged, it is noteworthy that the Board (and the presenting institutions) did not bother to comment on the prospects for discharge for three out of four cases presented as candidates for sterilization. Furthermore, for 6% of all cases presented (51 cases in the '1 in 5' sample, or an estimate of 255 cases in the total population of all cases presented), the recorded evidence indicates that the presenting institution was convinced that the patient could never return to the community. Sterilization was recommended nevertheless.

What are the implications of these findings to the construction of the problem? The "prospect for discharge" issue was part of the official definition of the problem –

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[14] Original Eugenic Board numbers have been changed to ensure anonymity of patients.

to be "safely" discharged from an institution, certain people were to be sterilized. Yet, in terms of defining the problem population, we see that this "official" definition of the problem had little impact on the actual behaviour of the Board. In other words, prospect for discharge was either not considered or if it was considered in the decision-making process, it hardly mattered. Sterilization was only remotely connected to one's prospect for life outside the institution. The fact that many people were sterilized and never released attests to this.

Summary and Conclusions

The above discussion provides a background description of the social characteristics of the people who were presented by the mental health institutions and sterilized by the Eugenics Board. Women faced a higher probability of being sterilized. Younger people (but not too young) were also targeted. Urban dwellers, and native-born Canadians were more at risk than rural and immigrant groups. Finally, Aboriginals were over-represented in terms of both presentation and sterilization.

The discussion also provided information on the types of activities and procedures carried out by the institutions and the Board: how did the Board go about carrying out its mandate? We saw the methods of control used by the institutions and the Board in carrying out their mission, how consent, diagnoses, IQ testing and prospects for discharge were used to justify presenting and sterilizing people. Also important to this process, and not analyzed above, is the use of the patient's family history, sexual history, diagnosis, and reason for sterilization to determine whether sterilization should occur. These variables are examined in detail in a later chapter. Specifically, they are analyzed to determine the way in which institutional staff constructed the patient's stories and what impact this construction may have had on sterilization. By looking at the reasons for sterilization, which the Board assigned after reading the patient histories, my objective is to more clearly demonstrate the ways in which the construction of family and sexual history, diagnosis, and reason for sterilization came together in the construction of this social problem. It is at this point where the official institutional constructions of patient histories/stories merge with

Board interpretations of the constructions to result in a final decision regarding sterilization.

Chapter 6

Minding Their Business: The Eugenics Board in Action

Analysis of Eugenics Board Minutes

In reconstructing the construction of the feebleminded in Alberta, it is necessary to look at the constructions provided by the Eugenics Board. These were the people who decided who should be sterilized based on their notions of what constituted a threat to society. Granted, they were appointed by the Government, but the reality is that they held the final decision-making power on who should be passed for sterilization. As such, their constructions are important and necessary to understanding the construction of the problem as a whole.

In attempting to understand the Board's stance on the problem of feeblemindedness and mental illness, the main data source analyzed is the complete set of Minutes of the 395 meetings of the Eugenics Board of Alberta. In using this source, my main goal is to look for ways in which the Board itself contributed to the social construction of this social problem. In other words, the Eugenics Board is examined as an interest group; what was the Board's role in creating the menace of the feeble-minded and also in providing a response to this problem? What were the important issues focussed on by the Board? What was worthy of mention in the meetings and so the Minutes as well? How did the Board members reach their decisions? Were there outside influences on the Board's operation? What role did the Board members see themselves playing in this whole process?

Another goal is to look for changing constructions of the problem in the meeting Minutes. For example, did the Board have certain conceptions and agendas earlier on? Did these conceptions change? If so, how did they change? What became the new focus? What were the implications of these changes? How did they reflect the concerns of other interest groups?

There are two social constructions that emerge from the Alberta Eugenics files. One social construction is that of the stereotype of the "feebleminded" person in Alberta. We have been focusing on this social construction up to this point. We saw in Chapters Two and Three how this "social problem" was constructed in the media and through various claimsmaking activities. We saw how interest groups and individuals influenced the passage of the *Sexual Sterilization Act*.

A second social construction is that of the mental health *process* in Alberta during this time period. This chapter and the next one are based on the Minutes of the Eugenics Board meetings. The analysis illustrates how the Board perceived its role in the province and how it constructed itself as playing a key role in improving the mental health of Alberta society. The Minutes reveal to us the roles played by the Board members, the government, and in some cases the provincial mental health institution representatives in the social construction of their activities and goals. In these chapters while the social construction of the feebleminded person is certainly lingering in the background, the focus is on the social construction of the mental health system and the process used to define the "feebleminded menace" behind the closed doors of the Eugenics Board meetings.

Starting to Tell the Story: Formative Meetings of the Board

Several themes emerge from the first thirty sets of Minutes of the Eugenics Board of Alberta. These meetings occurred between January 29, 1929 and December 31, 1931. In general, these meetings were crucial for establishing standards and procedures for the meetings to come. In a sense, the Board was attempting to establish its identity, its purpose, its role, and its approach to the issue of sterilization. It is within the pages of the Minutes of these first, formative meetings, where the major 'themes' that recur throughout the Board's operations, first emerge.

Expansion of Duties, Scope and Power

The first meeting of the Eugenics Board, on January 29, 1929 at 10:00 a.m. was a formative meeting. One of the first orders of business was to bring the Provincial Training School under the "*Mental Diseases Act*", which translates into bringing the School's 'clients' under the jurisdiction of the Board. Under *the Sexual Sterilization Act*, "when it is proposed to discharge any inmate of a mental hospital, the Medical Superintendent or other officer in charge thereof may cause such inmate to be examined by or in the presence of the board of examiners" (the Act). The Act also stipulates that in the Act ""mental hospital" shall mean a hospital within the meaning of *The Mental Diseases Act*"(Minutes, January 29, 1929).

Thus, at this early stage, the Board was attempting to expand its influence and control. Organizations seem to follow similar paths of development in the quest to attain rationalization (DiMaggio and Powell, 1983); often this involves a drive to attain and maintain legitimacy by expanding influence and control (Weber, 1968; Meyer and Rowan, 1977). The Provincial Training School dealt with patients deemed to be "mentally defective" and problematic. As such, it was not an institution that came under the purview of *The Mental Diseases Act*. By attempting to bring another institution (the PTS – Provincial Training School) under its jurisdiction, we see that immediately the Board began its social construction of the problem by defining mental defectiveness as mental disease. For this reason, expansion of business and power appears first on the list of priorities of the Board.

This pattern continues throughout the next 29 meetings but also beyond (to the remaining 370 meetings). Appended to the Minutes from meeting number 4 is an Order-in-Council, which had been approved and ordered by the Lieutenant Governor. This document enlarged the scope of the Board by making part of its mandate the task of instituting "inquiry into and collect[ing] information and statistics relating to all matters of public health and disseminat[ing] information in such manner and form as may be found best adapted to promote health" as related to the subject of eugenics.

In meeting number 6 on Saturday, October 26, 1929, the Board brought up several issues for discussion which directly relate to their attempt to expand the scope of their power/duties. This expansion also provides insight into the types of people they thought were a eugenic threat and who should fall under the domain of the Board. In other words, we get some insight into how the Board was constructing both its duty, and its definition or construction of who should be sterilized.

The Board discussed "the advisability of recommending enlarging the scope of the Act to include cases not confined to Institutions" (meeting no. 6). As well, the Board discussed "the question of the power of the Board to deal with cases of voluntary sterilization". The Board was attempting, with these two items of discussion, to push the limits of the *Sexual Sterilization Act* by trying to involve itself in *voluntary* operations, but also in reaching people who were *not institutionalized*. The Board also discussed the "question of medical certificates before marriage" as well as the use of contraceptives. It is possible that the Board was initiating these actions based on outside pressure or influence. However, there is no evidence (in the form of appended letters or articles, or names of people who may have contacted the Board to make such suggestions) of this kind of outside initiative, which gives the reader the impression that these ideas were the Board's own. No conclusions were reached on any of these topics at this meeting. However in a later meeting it was decided to approach the government about naming additional Homes and Hospitals as institutions under the Act.

Finally, at meeting no. 22 the Board again attempted to expand its jurisdiction: "At this point it was suggested that a recommendation be made to the Government that the Eugenics Board be empowered to authorize operations for sterilization for medical reasons…" The Board was attempting to work outside its "eugenic jurisdiction" and was entering into the purely medical field, to control people not deemed a eugenic threat.

The Board also took a keen interest in the expanding powers of institutions dealing with mental defectives. In meeting no. 6, the Chairman of the Board "spoke of the organization of extra institutional work under the direction of Dr. Fitzpatrick. He stated that Dr. Fitzpatrick had started Mental Hygiene Clinics in Edmonton and Calgary[1]. In Edmonton he had already established contacts with the Juvenile Court and would no doubt be able to establish similar contacts in Calgary". In meeting no. 10 more talk of bringing other institutions under the *Mental Diseases Act* occurred. Specifically, it was "decided that it is not feasible to have Beulah Home and Mount View Home named "institutions" under the Mental Diseases Act". It was however, "decided to ask for an Order-in-Council naming the Psychopathic Ward in the University Hospital Edmonton and a ward in the Calgary General Hospital Institutions under this Act." To illustrate the canvassing done to initiate such action, we find in these Minutes that "the Superintendent of both these institutions had already agreed to such procedure." Related to this, in meeting no. 21, the Chairman announced the creation of a new centre at the Galt Hospital in Lethbridge.

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[1] Mental Hygiene Clinics were travelling clinics aimed at uncovering mental defectiveness, among other things, primarily in rural areas of the Province. Case files indicate that many of the future clients of the Board were, in fact, 'discovered' through these travelling clinics.

The Board also seemed to want to influence responses to other sexually-related social problems within Alberta society at the time. Meeting no. 9 concludes with a discussion about "the problem of the lack of suitable living accommodation for working girls in the City" as well as "the matter of sex literature coming in from the United States".

Legal Concerns and Technicalities

At the first meeting, legal issues were paramount. The Board appeared to have realized the legal issues surrounding sterilization. One of the first orders of business at this meeting was the issue of personal liability of Board members and surgeons. According to a legal advisor present at this meeting "satisfactory conclusions have been reached in regard to the authority of the Act" in this regard.

Another issue discussed during the second meeting had to do with the interpretation of the phrase "that the patient might safely be discharged" back into the community. This phrase is Clause 5 of the *Sexual Sterilization Act*; people were to be sterilized if it meant they could safely return to the community. Issues surrounding the guardianship of people committed to institutions by warrant were also discussed. This is significant because, if considered a ward of the government, the only consent needed for sterilization was that of the Minister of Health. The Attorney General was also asked to rule on the concerns about expansion of the jurisdiction of the Board to voluntary sterilization and use of contraceptives.

In terms of the social construction of these 'problems', the Board was actively seeking formal governmental responses to their concerns and demonstrated a strong desire to have control over these issues. They were starting off with a broad construction of the problem, everything from people with mental diseases (formally their mandate under the Act), to mental defectives, to working girls, to contraceptives and sex literature. The common denominator of their concerns and the construction was sexuality.

Consent Issues

A common theme throughout the meetings up to 1937 is the "consent issue". In fact, at the first meeting, one of the unanimous conclusions reached is the following: "if at all possible, personal consent of the patient should be secured".

Much time and energy was spent discussing consent forms and procedures for securing consent. At the second meeting, a decision was made to ask the Attorney General's Department for a ruling on consent cases where either husband or wife offer or refuse to offer consent to the sterilization of a spouse. Almost as soon as the Board started seeing patients and passing them for sterilization, the Minutes of the meetings describe at least one, if not more, cases where consent issues were discussed.

There appears to have been a genuine concern for establishing proper consent before operations were conducted. Sometimes the Board seemed to go out of its way to get the consent of more than one person in a particular case. For example, in one case, the father gave consent for his daughter's sterilization, but the Board thought it best to obtain the consent of the patient herself. In another case, the patient herself had consented, but "it was deemed wise that the Minister's consent should also be secured" (meeting no. 15). In yet another case, the father consented to his daughter's sterilization, but the brother strongly objected, "so that the case was dropped in the meantime" (meeting no. 18). The Minister of Health was invited to another meeting to discuss a case where his consent was required. Finally, to illustrate the extreme measures taken to ensure proper consent, in one case the direction was to try to get the father's consent and if not "the Secretary was instructed to obtain legal advice as to procedure" (meeting no. 20).

This concern with consent illustrates the formal respect given to personal rights of the individuals and families affected by the sterilization decision. Part of the construction at this point in the development in the Board seems to be a respect for the rights of its clients as thinking human beings. This concern is reinforced by the amount of time and effort spent on each patient's 'write-up' in the Minutes. Whereas in later Minutes each person gets only one line which includes minimal information, in these earlier Minutes each patient gets at least one, sometimes two or three paragraphs outlining all the details of the case.

This concern for and respect for the patient is reflected in the last paragraph of the Minutes for the second meeting:

> In connection with the discussion of the whole problem of

> sterilization, several other questions presented themselves. A very important one was: --the possible effect of the operation on the patient, physically, mentally and morally. It was deemed advisable that an effort should be made to get all the information possible bearing on these problems from centres where sterilization has been practised for some time.

Also related to this concern was the fairly frequent extensions given to patients before sterilization occurred, and the almost routine decision for further extensive physical examinations before a decision would be made. Specifically, by meeting no. 50 (March 17, 1933), 24 extensions (90 day) had been given to patients presented to the Board.

There was also concern for a need for Social Workers to collect information on patients and to conduct follow-up reports after the operation takes place. Minutes from the early meetings stress the importance of having social workers assigned to work with the Board and institutions on these cases. During meeting number 3 the Board decided that much information will be needed on each case and that such information "could be obtained only through the agency of trained social workers". By meeting number 5, Mr. S. Jaffary had been appointed by the government as Social Worker for the Mental Hospitals. At meeting no. 10, after discussing the expansion possibilities of the Board's influence, the Board "decided to recommend that more social workers be engaged for the investigation and preparation of cases."

Surgeon Issues

Another recurring theme throughout the early meetings is the appointment of surgeons to perform sterilization operations directed by the Board, as well as the payment to be received by these surgeons. First mention is made of surgeon appointment in meeting no. 4 when it "was decided that letters should be sent to all the Registered Specialists in Surgery in the Province asking them if they would be willing to perform an operation for Sterilization if called upon to do so by the Board". Fees, it was decided at this meeting, should "be in accordance with the Schedule laid down by the College of Physicians and Surgeons of the Province. At the next meeting, this decision, to approach all surgeons in the province, was rescinded. Instead, the Board would appoint a surgeon to each case.

Meeting number 11 was devoted specifically to the topic of surgeon fees. The Chairman started the meeting by stating that at the "present rate of surgeons' fees the cost of administration of the *Sterilization Act* was likely to prove too expensive for the Province". The goal was to reduce the cost of operations and four reasons were offered as to why the costs should be lowered. It is worthwhile to list them here. They reveal interesting insights into the Board's operation and vision of its future activities.

> 1) It has been the policy of the Board to appoint not more than three surgeons in the Province to perform operations.
> 2) These operations fall outside the regular practice of the surgeons concerned.
> 3) They are performed at the expense of the public.
> 4) *They will no doubt steadily increase in number*. (italics added)

Discussion ensued during which suggestions were made to reduce costs. It was also suggested that Dr. Conn and Dr. O'Callaghan be appointed "honorary surgeons to the Board; that in this capacity they should perform all operations assigned to them by the Board, themselves assuming all responsibility for the fees of assistant surgeons and anesthetists; and that they should in consideration of these services each receive an honorarium of $300 per month". The Board did agree though, that "when the number of operations performed in a year increased beyond 100, a reasonable increase in the honorariums allowed should be considered".

How is this relevant to the social construction of this problem? We see that early on in the Board meetings, selected physicians were given power and a monopoly on the operations to be performed. Of course, along with this comes a monopoly on payment for services rendered. In other words, the Board, in its actions regarding physicians, showed them and the rest of the people concerned that physicians were important to this process and were rewarded accordingly. It is quite likely that the surgeons were actually being paid less per operation under the honorarium than they would normally be paid (in their regular practices). However, since the work was steady (and in addition to their regular work), and the Board allowed for an increase, there was a monetary benefit to being affiliated with the

Board. We see later that physicians were given even more power; they were given power to make individual decisions regarding sterilizations without Board consent[2].

In terms of the social construction of the problem, this means that a select group of very intelligent, well-educated, prestigious, and powerful men were given the power to influence who was sterilized. It is likely that a group of select, powerful physicians with social and economic status would have little in common with the types of people being presented to the Board for sterilization. They likely could not identify with these people and so, in constructing the problem, their roles would be significant. They may not be inclined to defend the feebleminded, but rather, faced with an opportunity to operate (and be paid for it) and prevent the 'undesirable' group from reproducing, they would likely embrace it. These were also members of the helping profession; they did it in the name of science and medicine, and in the name of the people they were 'helping'.

Publicity Campaigns

The Board appeared to take the Order-in-Council that expanded its duty to include collection of information and statistics and dissemination of information very seriously. These attempts began directly with the medical profession, perhaps as a means of soliciting business or promoting and justifying the 'cause'? At meeting no. 5, two of the doctors in attendance moved and seconded that a copy of a report on the first case of sterilization be sent to all the members of the medical profession in the province. This decision was rescinded at meeting no. 8. No reason is given in the Minutes for this decision, although one can speculate that it might be an act of caution. The Board may have thought better of 'advertising' their work so soon for fear of backlash or controversy. Or, it may have been because they had decided at an earlier meeting that only a few doctors would be affiliated directly with the Board as its appointed surgeons.

In meeting no. 5 the Director of the Division of Social Hygiene also suggested, "that arrangements be made to impress upon the Medical Profession the importance of the early diagnosis and treatment of G.P.I. cases" (General Paresis of the Insane). This topic was brought up again during meeting number 9; the suggestion was to have special lectures on this topic. It was decided at this meeting to "ask the Canadian Medical Association to provide lectures by a neurologist in connection with their travelling clinics. It was further agreed to write Dr. George Johnson asking him to support this request". In other words, the Board was actively involved in getting others involved in promoting the cause, and educating people about the necessity of sterilization.

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[2] There are examples, discussed below, where surgeons performed operations without Board approval. As well, surgeons were given the discretion to make a decision at the time of surgery regarding which procedure should be performed. For example, "salpingectomy or hysterectomy at the discretion of Dr.-—" often appeared in Eugenics Board forms.

Educational Links

The Board was aware of the importance of research in the area of eugenics. As such, it seems to have made a point of keeping up on the latest research developments. As early as meeting number 5, the Chairman informed the other Board members of a new book by Gosney and Popenoe, *A Summary of the Results of 6000 Operations in California, 1909-1929*. He announced that he had placed an order for copies for the members of the Board.

Mention was also made at this meeting of cooperation between one of the doctors involved with the Board and the Department of Psychology at the University of Alberta (the Chairman of the Board was a University of Alberta Professor). Furthermore, "a grant from the Canadian National Committee for Mental Hygiene had made it possible to undertake certain educational and research work in Mental Hygiene in the University". In fact, "three graduate students had been appointed to Fellowships and would cooperate in the clinical and research work". In other words, the CNCMH, which actively campaigned for a eugenics program in the prairie provinces funded three graduate students from the University to conduct research on this topic and to cooperate with the Eugenics Board. Meeting no. 5 ends with the following, telling quote:

> The Chairman looked forward confidently to the further development of this side of the work and expressed the sincere desire of the University to cooperate to the fullest extent with the Department of Health, in its effort to cope with one of the most serious problems of today.

The Remaining Minutes of the 1930s Meetings

Consent and Concern for Patients: Shifting Constructions of Individual Worth/Merit

After the initial formative meetings (meetings no. 1 to about no. 30), there appears to be a new set of themes that emerged. There is definitely overlap: the original 'themes' do not disappear. But gradually they seem to give way to new concerns on the part of the Eugenics Board -- new variations on the old themes. For example, the consent issue continued to be a concern for the Board, at least until 1937 (when the Act was amended to reduce the number of conditions under which consent was required). The ninety-day extensions that seemed to be handed out to patients quite frequently also continue – until meeting no. 50 (March 17, 1933).

A general concern for patients continued up until this point as well. The Board seems to become very concerned about the importance of follow-up reports on patients who have been sterilized (see Appendix 6). The follow-up reports were based on visits from social workers who interviewed the patients and families after the operations to see what the effect has been on the patients' lives. The social worker then presented these reports to the Board. Initially, the follow-up reports played an important role in the operation of the Board. Later on, however, we see that they virtually disappear from the Minutes. Whether or not the Board still continued with such reports, we do not know. But what is apparent is that they disappeared from any record the Board left of its activities. From this we can assume that the reports became less important to the Board.

To illustrate the importance of the follow-up reports in the early meetings, we see that in meeting no. 29 "on account of the unfavourable follow-up reports on four of the cases already dealt with by the Board, the Chairman was requested to prepare in consultation with Dr. Baragar a recommendation to be presented to the Minister for some better system of follow-up and control of all cases dealt with by the Board." Follow-up reports continue to be completed and presented; at meeting no. 47 (December 17, 1932), 110 follow-up reports are presented and in fact "on behalf of the Board the Chairman expressed appreciation of the excellent follow-up reports of the social workers." At meeting no. 52 fourteen follow-ups are presented. Meeting no. 53 saw another fourteen case follow-ups are presented. At meeting no. 58 twenty-nine case follow-ups are presented to the Board. Meeting no. 59 saw thirty-six such follow-up reports; meeting no. 66, twenty-three.

After this, there is little mention of follow-ups until meeting no. 99 (December 18, 1939) when "the Board discussed the desirability of having a more comprehensive system of follow-up reports on Eugenics Cases and operations, and also the desirability of having additional information on the children of patients presented. The present personnel available, and the amount available for travelling expenses, does not allow much investigation work to be done in many of the cases."

What do the follow-up reports mean for the construction of the problem of feeblemindedness? Earlier it appeared that concerns surrounding these reports, in combination with the apparent concern for consent expressed in the Minutes, indicated a general concern for patient welfare. The Board wanted to make sure patients knew what was going to happen to them; they wanted to make sure they had patient (or someone close to the patient) approval. After the operation occurred, they wanted to be informed of the patient's adjustment to life after sterilization.

But what does it mean when the Board, within the same decade, makes a 180-degree turn? In its formative meetings, the goal was to get more social workers involved in the Board's work. There was a push for more funding and a more rigorous procedure for following up on patients after their involvement with the Board. But eight years later, the discussions surrounding this issue indicate resignation, a "giving up" on the follow-up reports, because of lack of funding, lack of personnel. To illustrate, at meeting no. 98, October 12, 1939, "the Secretary presented to the Board members some follow-up notes on Eugenics Board cases, which were reviewed briefly…" Now they are follow-up *notes* and they were discussed 'briefly'. It appears from both the lack of such follow-ups and the reduction in time spent on them during meetings, that they had diminished somewhat in importance.

This may also be indicative of the general path the Board began to take, a path that witnessed a lessening of interest in the welfare of the patient. Amendments to the Act during this decade took away the necessity of consent for certain cases. One of the primary initiators of the Amendment was Dr. C.A. Baragar, The Director of

Mental Health for the Province, and an active participant and presenter at Eugenics Board meetings. For several years leading up to the Amendment he had been urging the removal of the consent requirement for mental defectives (Christian, 1974: 27).

We also witness a drastic decline in the frequency of follow-up reports being discussed at the meetings. The reduced concern on the part of the Board in terms of patient rights indicates that patients were constructed as being less important. They were being viewed less as thinking human beings with rights and protections and more as 'objects' to be dealt with, 'objects' who were not capable of consent and whose adjustment and welfare after contact with the Board was irrelevant.

Concern for patient welfare goes hand in hand with patient consent. Consent is a complex issue because it can be interpreted in different ways. Concern and caution regarding patient consent might indicate a view of the patient as a human being worthy of consideration. Concern regarding consent might also indicate caution regarding the legality of invasive surgery. The Board's preoccupation with attaining the consent of patients, particularly in the formative years and meetings needs to be interpreted with caution.

The consent issue is particularly interesting in the 1930s' minutes because of the Amendment to the *Sexual Sterilization Act* that occurred in 1937. Prior to the Amendment we see a consistent and strong focus on the issue of consent. After 1937 a very different story unfolds. As early as meeting no. 55 (June 16, 1933) we see the beginning of what turns out to be a progression toward less concern with consent and more concern with getting the job done no matter what it takes. This reaches its height with the Amendment to the Act. But before the Amendment occurs, we already see the progression that leads to these drastic measures.

It appears from the Minutes that consent turned into a different sort of issue during this decade. At the outset, consent was something to be concerned about; it should be obtained according to proper procedure. It was a serious decision made by patients and/or their families that was also taken very seriously by the Board. But in time, the consent issue takes on a somewhat different face. Consent is now constructed as an obstruction, a roadblock that is standing in the way of progress and a thorn in the side of the Eugenics Board. For example, at the June 16, 1933 meeting (no. 55) we see the case of a ward of the government being presented to the Board. "Her mother lives in Saskatchewan and both she and her husband (stepfather of the patient) refused to give consent to the operation. For this reason the case was not passed. *It was suggested that the patient should be sent back to her family*" (italics added). It seems like the Board is making a statement here: if we cannot deal with this person the way we see fit (sterilization), then we do not want to deal with her at all. Send her back to her parents and let them take care of her. Perhaps the Board is going to make this case an example for others? Why else would the child be sent home? She does not appear to be causing any problems in the institution where she stays – her institutional behaviour is not brought up at the meeting as a concern. There does not appear to be any other reason for sending her home, other than making a statement and possibly coercing parental consent.

"Consent issues" are mentioned in 64% of the 69 sets of minutes for the remaining 1930s. A classification of these consent issues is discussed next.

Locating family

In 12% of the Minutes from 1932-1939 some mention is made of trying to locate the patient's family in order to attain consent. For example, at meeting No. 60 (March 15, 1934) this consent-related issue is discussed. It seems that occasionally the Board was unable to reach the parents or family of certain patients. It appears that contact was attempted through mail. While the Board does not indicate time periods allowed for such contact, or even whether they were aware that perhaps literacy might be an issue, what we do sense is frustration on the part of the Board. "[C]onsent of patient and his father. If no reply was received from the father it was agreed that the Minister's consent should be obtained." At meeting no 64. (September 13, 1934) we see a similar situation: "…consent of parent or if they cannot be located the consent of the Minister of Health will be required." How much effort was put into locating parents?

Coercion of Consent

Another consent-related issue concerns 'convincing' that may have occurred, or possibly 'shopping around' until someone was found who would consent. This issue is mentioned in 13% of the Minutes from this era. On March 15, 1934 (meeting no. 61), one of the doctors presenting cases reported that one patient's uncle had refused to give consent for the sterilization of his nephew. "It was decided by the Board that a *further effort* should be made to secure the consent of the uncle" (italics added). This 'further effort' phrase does leave some unanswered questions. What does 'further effort' entail? On June 14, 1934 (no. 62) a case was passed subject to the consent of the father. "If the father refuses consent Dr. Baragar is authorized to investigate and consult the brother." Not only was subtle coercion occurring, but also "shopping around" until the right answer was obtained. Interestingly, Usborne, in her analysis of sterilization programs in Weimar Germany states that case material supports the notion that doctors performed operations by stealth (1997:75). In fact, such material "shows they used moral pressure, deception, or duress in order to perform the surgery. This suggests they feared consent would not be freely given" (75). While not necessarily implying that Eugenics Board members and surgeons used similar tactics, it is worthwhile to note that such tactics were not outside the realm of possibilities in implementing sterilization programs. At the very least, such information should make us wary of some of the ways in which consent issues were dealt with by the Board.

Much later on, at the September 29, 1936 meeting, we find more evidence of this type of indirect coercing, although this time of a very different nature. There are two cases, both young girls whose parents are dead and who live with their brothers. The question of consent is raised since "neither girl is capable of giving consent." A representative of the Attorney General's Department has this advice to offer: "Under these circumstances, I am of the opinion that the board would not have jurisdiction to order the operation without the consent of the Minister." However, this person goes on to suggest that even though the brothers' consent has no legal effect, the Board should get the brothers' consent anyway and then present the consent to the Minister to "illustrate to him their attitude." The Board is very "thorough" in attaining consent in this instance.

No patient consent

It is during the September 13, 1934 meeting that we see the first real signs of the Board starting to downplay the requirement of patient consent. In fact this issue appears in 7% of the 69 Minutes from this era. One case was "passed subject to the following conditions. The husband's consent had been obtained, but the patient who had not recovered from her illness had refused consent. It was decided that the case should be passed *subject to the approval of the legality of performing such an operation without the patient's consent*. Dr. Baragar was requested to submit this matter to the Attorney General's Department for a ruling" (italics added).

Several issues are raised by this entry into the Minutes. First, there is the consent issue. The patient has refused consent; the Board is trying to over-ride this refusal and instead go with the person who *has* consented. It also has the potential to set a precedent. By turning to the Attorney General for a ruling, the Board is attempting to set a new precedent for cases like this. This in itself is very interesting, since the next day, at the next sitting of the Board, we see a very similar case being brought up for discussion. It is identical: the husband had consented but the patient had not and since she was not fully recovered from her illness, the decision was to refer to the Attorney General again. These cases indeed seem to set the stage for the upcoming move to amend the Act (and as mentioned above, Dr. Baragar was instrumental in initiating the amendment). The fact that these women were not 'fully recovered' implies incapacity to make a decision. That is precisely what the Amendment addressed: cases where patients are 'unable' to consent.

A second issue raised by these two examples is the fact that in both cases, the patients are women. The 'sick' woman who even when healthy has doubtful decision making abilities, certainly should not be responsible for making this type of decision. That this occurs during the patriarchal 1930s is not surprising. In both cases, the husbands *have* consented. These examples provide support for the construction of the weak, sick, hysterical woman patient, which was fairly prevalent in society during this period in history. This construction also sees women as being primarily responsible for bringing weak, defective children into the world. Their reproductive potential is to be controlled, by husbands, by doctors, by the Eugenics Board.

It seems that the Attorney General's Department came through for the Board in these cases because, on December 17, 1934, we find a case passed subject to the consent of the patient and her husband. However, "if on discharge the patient is not competent to give consent the ruling of the Attorney General's Department will stand – i.e. the consent of the husband will be all that is required."

Another case that relates to this gender/consent/patriarchy issue concerns the case of a girl presented on June 14, 1933.

> The patient's and the mother's consent had been obtained. The father, Mr. Kibblewhite the Social Worker stated, was willing that the operation should be performed, but did not wish to sign the consent forms. He was willing that his wife should take full responsibility for giving consent for the operation. The Board agreed to pass the case subject to a ruling from the Attorney General's Department that the mother's consent was sufficient.

In this case, the woman's consent, though she is not mentally incompetent, is still questionable. Her consent had to be approved by the government. The father's behaviour indicates perhaps his recognition that what was going on was not right. But in not exerting his own power, he could place responsibility with his wife, after government approval of her competency.

Patient's Unwarranted Consent

What appears as an interesting contradiction on the part of the Board, or maybe more of an illustration of their uncertainty, occurs at meeting no. 99 on December 18, 1939, and reappears twice in future meetings in the 1930s. The Amendment has been passed. "Mental defectives" no longer need to give consent to the operation. Yet here we have a case that is "passed clear". However, what is unusual is that added to this decision is the comment: "Patient has consented and is mentally deficient." Something is amiss here. Consent is *no longer required* from such a person. Furthermore the Amendment was based on the argument that mentally defective people are incapable of giving consent. Here, though, the mental defective *has* consented. The Board thought it worthy to mention that this person, whose consent has been legislated NOT to matter, has consented. I will return to this issue later in this chapter.

Consent Efficiency

The Minutes also show that consent was obtained *before* meetings, likely to make the meetings and decision-making more efficient. This occurred in 16% of the meetings in the 1930s. March 25, 1934 saw the passing of several cases unconditionally, because "the patient's consent was in order". This had to involve talking to the patient, processing the forms, and essentially making the decision in advance (or at least being fairly confident that the decision to sterilize would not be questioned). In other words, institutional staff members were so sure of their constructions of these people, and of how the Board would respond, that they were confident enough to get the forms signed before the patient even appeared before the Board. What does this say about the process itself and the treatment of patients? Was the meeting merely a formality in these cases? Was the Board simply putting the final stamp of approval on a process that began and was essentially completed long before the Board met?

Amendment to the Sexual Sterilization Act

The 1937 Amendment was definitely one of the highlights of the Board's operation during the 1930s. The Amendment, as discussed earlier, gave the Board (and the mental health institutions) much more freedom in deciding who should be sterilized and who should be required to give consent. Official mention of amending the Act is not made until meeting no. 79 (January 28, 1937): "In view of the conference between the Minister and the Board, to be held on the following day, the Board discussed the various clauses of the *Sterilization Act*, and possible amendments."

On January 29, 1937, the Board members, after their regular meeting (no. 81), reconvened at the office of the Minister of Health where they discussed "desirable amendments of the *Sterilization Act*." The Minutes for meeting no. 82 (April 23, 1937) contain an attachment that explains the Amendment to the Bill. It is not the Amendment itself, but rather an explanation of it. It reads as follows:

> Bill No. 45 of 1937. A Bill to Amend the Sexual Sterilization Act. Note. This Bill amends The Sexual Sterilization Act by bringing within its provisions mentally defective persons who have been under treatment or observation at a Mental Hygiene Clinic. Section 4 makes provision for the making of a sterilization order in the case of a psychotic person and as to the requisite consent to the operation. Section 5 contains provisions as to the making of a sterilization order in the case of a mentally defective person. Section 6 restates and amplifies the immunity of surgeons and other persons from civil actions or proceedings for any thing done by them

> in good faith and in purported pursuance of the Act. R. Andrew Smith, Legislative Counsel. (This note does not form any part of the bill and is offered merely as a partial explanation of some of its provisions.)

About a month later (May 31, 1937) a "special meeting was held". "The primary purpose of the meeting was to reconsider a group of those cases already presented, but which might be considered for a different disposition under the recent amendments to the *Sexual Sterilization Act*." Thirty cases were re-presented at this meeting (24 males and 6 females). These cases, previously outside the scope of the *Sexual Sterilization Act*, now were within the realm of the Eugenics Board's jurisdiction. Clearly, the Amendment made the Board more effective.

Following the Amendment, we see in the Minutes several cases where patients previously presented are up for 'reconsideration'. Here is an example: "The case of Mrs…came up diagnosed as psychoneurosis. It was agreed that a psychometric be done, and should this show any degree of mental deficiency that the case should be reconsidered." Not only were cases being reconsidered, they were also being *re-tested*. The Amendment issue overall gave the Board members more power than they had previously. They could now make decisions regarding sterilization without consent from the patients. They could re-test the patients searching for any sign of mental defectiveness that would allow them to disregard the obtaining of consent. But at meeting no. 84 (July 15, 1937) we see a different sort of power being exerted. "Dr. E.G. Mason raised the question as to whether or not defectives were to be approached for consent. The Board decided that they would proceed according to the Amendment, *except in special cases where consent was deemed advisable*."

Why was the Board concerned with making exceptions to the Amendment? The Amendment clearly stated that mental defectives no longer had to consent. Why this indecision? Perhaps we have another instance of Board members' doubt about the wisdom of the Amendment, about the idea of removing the necessity of obtaining consent from 'mental defectives' to give such consent.

As with other activities of the Board that are discussed later (specifically, the research occurring with testicular biopsies from "mongoloids" when the Board had evidence of research showing they were sterile), the Board had information that consent was a sticky legal issue. Appended to the May 5, 1936 Minutes is an excerpt from an article on "Sterilization of Women" which appeared in the *British Medical Journal*, February 23rd, 1935. This article stresses repeatedly the legal position on sterilization without consent. It is very definitely opposed to the practice. Specifically the article states that

> it had long been held that the person's consent was not a defense in a charge of maiming. Therefore…eugenic sterilization would probably be held to come under Section 20 of the [Offences Against the Person Act]: "Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of a misdemeanour, and being convicted thereof shall be liable…to be kept in penal servitude.

The article goes on to state that: "With regard to lunatics and mental defectives, if the sterilization of normal persons was a crime, the sterilization of persons who could not give consent and did not properly understand what was proposed would be so much more a crime…". The Board likely focussed on the closing paragraph of the excerpt: "The sterilization of a person for reasons of health was always lawful; for eugenics reasons, probably unlawful; for reasons unconnected with health or eugenics, certainly unlawful; and in the case of lunatics and mentally deficient person, always *unlawful unless undertaken for health reasons*" (italics added).

As long as sterilization for health reasons could be justified, the sterilization process and also the lack of consent on the part of mentally deficient patients would be a moot issue.

The Board's Cutting Edge: Expansion to More People and More Procedures

Bringing more people under its influence

The Board was concerned with expansion of scope in its formative meetings. This concern continued throughout the 1930s. As with the earlier meetings, there was a definite interest in increasing the range and number of people over whom the Board had influence and control. Hiring more staff, increasing the type of people over whom the Board had jurisdiction, and pushing for the inclusion of castrations[3] as operations recommended by the Board were topics covered in over 16% of the meetings during this decade. For example, "after some discussion it was recommended that the Superintendent of the Institution concerned communicate with Dr. Harold Orr regarding the desirability of examining families of certain patients for syphilitic infection" (meeting no. 29, December 17, 1931). The goal here was to expand the Board's jurisdiction to people NOT within institutions but rather the *families* of certain individuals who came before it (outside the jurisdiction of the Board). Another example of this desire to expand control occurs on December 18, 1939. Here the Board discusses the "desirability of having additional information on the children of patients presented", again widening its scope of influence.

Another instance of the Board attempting to bring more people under its influence and control occurred at the October 13, 1937 meeting (no. 85). The Board was seeking to expand the geographic territory over which it had access. It appears that the northern parts of the province were relatively untouched in terms of eugenics practices at this point in time. "The question of the Board's visiting the Grande Prairie – Peace River district was discussed. Requests have been made on several occasions for this to be done. The Board expressed its willingness to go, and details of possible arrangements were discussed...".

The Board, at its April 26, 1939 meeting expressed concern with expansion of services. "The possibility of having vasectomies performed at the Provincial Mental Institute was discussed. The Board agreed to go into the matter further at the Provincial Mental Institute if necessary."

Finally, in terms of expanding the number of people over whom the Board had influence, there is a letter from the United Farm Women of Alberta appended to the December 7, 1937 Minutes (meeting no. 87). This group is asking for a "further broadening of the sterilization act so as to include cases not at present in the Mental Hospitals." They also wonder "what would be the best way (in case of any suspected case) of having someone brought to the attention of the Clinic in rural districts where there is no district nurse." There is a desire to expand the Board's 'service' not only on the part of the Board, but also on the part of at least one interest group in the province.

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[3] The Board was concerned with reducing sexual activity in some patients and was convinced that castration was a more appropriate option in such cases.

Castration

The Board was concerned with expanding its influence over people in terms of numbers and districts, but there is evidence also that it wanted to expand its influence in terms of "degree" of sterilization and operative procedures. It becomes obvious at meeting no. 63 (June 14, 1934) that in some cases, the Board believed that castration was warranted. The castration theme becomes a recurring one from this point forward in this set of meeting Minutes (the 1930s). Much effort was expended on the goal of legalizing the Board's control over castrations. Initially,

> the case of.... was presented to the Board, and after some discussion it was agreed that castration rather than sterilization was indicated. It was decided 1) request Dr. Baragar to consult the Attorney General's Department with a view to ascertaining if the father could legally request this operation to be performed, and if so to 2) approach the father with a view to having him request the operation to be performed at the expense of the government.

In this example, we see how the Board wanted to legally expand its influence. We also see some of the 'convincing' and 'behind the scenes work' that occurred; offering to pay for the operation, and 'approaching' the father both fall under this type of behaviour. The Board had a job to get done (in this case a castration) and it covered all bases in attempting to get it done efficiently.

At the next meeting (September 14, 1934), we see the Attorney General's ruling regarding the request for castration. "It was the opinion of the Attorney General's Department that such an operation could not be authorized by the Eugenics Board as it did not come within the scope of the *Sexual Sterilization Act*." Yet, despite this advice, the Board in this very same meeting creates several 'test cases' to present to the Attorney General's Department. They want to obtain from the Department a ruling on these test cases "as to the authority of the Eugenics Board to approve of sterilization by castration." This, despite just being informed that castrations do not come under the scope of the Act.

It is worthwhile to discuss further these 'test cases' the Board considers worthy of castration, since they provide us with some insight into Board constructions regarding people who needed to be sterilized. For example, in each of the three test cases the person has recovered, or is close to being recovered from a psychosis (in addition to being mentally defective), and also has "morbid sexual propensities" (ostensibly the reason for the castration and not 'simply' vasectomy). Examples of a morbid sexual propensity as listed in the test cases include indecent assault and exhibitionism. The question that begs to be answered is whether recovery from psychosis might in fact eliminate one's urge to commit indecent assault. There is also the question of whether the indecent assault was a one-time event, influenced by the situation at the time. Exhibitionism has been constructed as a morbid sexual propensity worthy of castration.

At the December 17 meeting, a response is received from the Attorney General's Department. The Board does not discuss the content but rather files the letter for future reference. We can only speculate as to the content. If the Board had received a favourable decision, it is likely that the cases where castration had been requested in the past would have been quickly re-presented, but they were not. It is likely safe to assume that the Attorney General's Department rejected the Board's request for a positive ruling on castrations.

Castration is discussed again at the May 22, 1935 meeting. "With respect to Case No…the Board agreed that in this case castration rather than vasectomy was indicated. It was the feeling of the Board, however, that although there was nothing in the act to preclude the authorization of such an operation, it was unwise to do so at the present time". Either the Board has forgotten earlier advice from the Attorney General's Department stating that castration was not within the scope of the Act, or else the ruling on test cases that had been received earlier indicated some support for such a procedure. Whatever the case, it is clear that Board members were preoccupied with this more invasive operation.

On October 13, 1937, the Board discussed the case of a patient up for re-consideration. "The question to be decided is whether or not the Board can direct an orchidectomy[4] when the patient has been sterilized already, a vasectomy having been performed." The case is to be "taken up with the Minister and the Attorney General's Department." The Board is essentially asking to conduct a more invasive surgery on someone who has already been sterilized once.

The last we hear of castration/orchidectomy occurs at the July 14, 1938 meeting where one of the doctors/Board members brings up the case of a male who is not mentally deficient but has a diagnosis of "psychopathic personality". "In view of the patient's action previous to his admission to the Provincial Mental Hospital Dr. E. G. Mason expressed himself as opposed to vasectomy and in favor of orchidectomy." The conclusion is to discuss the case with the Attorney General. But again, the Board's goal is to get permission for a more invasive operation, going beyond 'mere' sterilization. The Board wants to influence not just reproductive capabilities but also sexual behaviour. The Board is also pushing the limits of the Act putting pressure on the Government to give them more choice in sterilization procedures. We see later that orchidectomies became a fairly frequently-performed operation throughout the reign of the Eugenics Board.

Initial Exertions of Power: the Arrogant Board.

In its persistence to obtain approval for performing castrations, the Board exudes confidence bordering on arrogance. This attitude is also exhibited in the Board's display of power in the Minutes of the meetings. This "muscle flexing" is not necessarily conscious, but it is present. It is evident in the actions of the Board as a unit, but we also get glimpses of it in the actions of individual members. The power of the Chairman of the Board and the individual Board members and surgeons is a theme evident in 43% of the meeting Minutes in the 1930s. The Board has power, power invested in it by the Government, through the *Sexual Sterilization Act*. The individual members of the Board have power – power invested in them through their roles as doctors, professors, Superintendents of Institutions, and through the *Sexual Sterilization Act*.

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[4] Removal of the testes.

The Chairman and Individual Members

The most powerful individual on the Board was the Chairman, who from 1929-1965 was Dr. MacEachran. At meeting no. 55 (June 16, 1933), this power is demonstrated when "it was agreed that in future the Chairman might have *power* to extend the time during which the operation should be performed." (italics added) Here we have an individual empowered to make decisions, on his own, regarding the fate of Eugenics Board patients.

While examples of the exercise of power on the part of the members of the Board exist throughout the decade, there are some specific incidents that illustrate this point particularly well. On June 16, 1933, discussion centred around the case of a patient where an

> emergency operation for appendicitis had been necessitated before the meeting of the Board. Dr. O'Callaghan consulted Dr. Mason personally and Dr. Pope by long distance regarding the advisability of performing the salpingectomy at the same time as the appendectomy. He also endeavoured to consult the Chairman by long distance, but the operator was unable to locate him. All papers including the consent forms were in order before the operation was performed. The Board agreed that this case had been properly handled and confirmed the action taken. It was agreed that in such emergency cases in the future, *Dr. Mason and Dr. Pope should be given authority individually to act for the Board.* (italics added)

This case illustrates the power granted individual doctors to essentially make decisions that, according to the Act, are reserved for the four Board members. What constitutes an emergency? Is an appendicitis operation an emergency warranting sterilization? The salpingectomy was not the emergency operation, the appendectomy was. The salpingectomy did not *need* to be done at the same time. But perhaps the larger issue concerns the last italicized statement in the quote above: what does this action of giving these doctors individual power to decide the fate of patients say about the Board meetings generally? Are they 'just a formality'? Is it a foregone conclusion that if you are slated to be presented, if your 'forms are in order', you will likely be approved? If so, why bother having the meetings? Why bother having appointed four members to the Board? Why bother 'presenting' people? But the bottom line here is that Dr. Mason and Dr. Pope have been bestowed with the power of the Board. Two individuals have vested in them as individuals the decision-making power reserved for a government-appointed body of four.

The September 23, 1933 minutes have an "Addenda" attached. Here we see some possible demonstrations of power on the part of the Board. In one discussion, the Board seems to disregard proper bureaucratic procedure. Since the last Board meeting, two doctors had been appointed consulting surgeons to the mental institutions. "Dr. Baragar stated that while the appointments had not been formally confirmed it would be quite safe for the Board to proceed on the assumption that they would be confirmed." Related to this point, it was decided that "all vasectomies should be assigned to Dr. O'Callaghan" and that in cases of salpingectomies "the Board leave it with the *Superintendents* of the Mental Hospital, Ponoka to decide which cases should be assigned to Dr. Conn and which cases to Dr. O'Callaghan." (italics added) In the first case, one doctor gets the monopoly on vasectomies and in the second instance, the superintendents have assigning power. One interpretation might be that the Board members were merely being efficient in accelerating notoriously slow bureaucratic procedures. An alternative interpretation might be that the Board was exerting its power.

We see another example of this "power of the individual" on October 12, 1939. Here, Dr. Mason reported to the Board on having seen a particular patient and "as requested by the Board as its last meeting, had given final authorization to operations indicated." Nowhere in the Act is anything left up to an individual Board member. That is why the Board is composed of four members. Again, we see exceptions made to procedure; exceptions that empower individuals to give 'final authorization' for operations.

We saw in the discussion above that when blocked by the *Sexual Sterilization Act*, the Board would appeal to the higher power of the Minister of Health or the Attorney General's Department. The Board was backed by senior politicians. Who would a patient turn to for extra support and backing? Power differentials between Board and patient were vast. There are many such examples. One occurs on November 26, 1936: "…It was agreed by the Board that, in this case, sterilization was indicated, but that the case did not come within the scope of the Act. It was, therefore, deemed wise that it should be referred to the Minister for his consideration." Could a patient also ask the Minister for consideration in appealing the decision to sterilize? Likely, but because of power differentials, differences in education and awareness of such options, no patient did so. Several patients died in the thirties as a result of complications from their sterilization operations. The Board reviewed all the cases and was satisfied with the way each of the cases was handled. What recourse would the family of a feebleminded person have if negligence had contributed to the death? Who would question the way the case was handled?

Patient Agency

This study is about the construction of the feebleminded threat. As such it is not about *resistance* to this construction on the part of the powerless. However, we do see some evidence of patient agency, patients attempting to exert what little power they may have had. First and foremost, it is significant that while 99% of patients were approved for sterilization, 40% of these patients were not sterilized. Through exercising their right to withhold consent, many patients did in fact exert power. Such exertions of power on the part of patients are discussed in about 6% of the Minutes. Since I did not speak with the people who resisted all I can offer are some speculations as to why so many of them were able to and did resist sterilization.

Some patients may have been stubborn and took their right not to consent seriously. However, it appears that gender, decade and presenting institution likely played some role in the ability of patients to exert their agency. Only about 40% of all individuals presented in the 1940s were ultimately sterilized, compared to about 50% in the 1930s and about 70% or more in the 1950s, 1960s, and 1970s. In addition to this, there were shifts in the relative proportion of cases presented by the four main "feeder institutions" over the years. Essentially, Ponoka gave way to the Provincial Training School and Oliver as key players. Over the years, 43% of cases presented by Ponoka were eventually sterilized, compared to 70% of cases presented by Oliver. In contrast, approximately 90% of cases presented by PTS and Deerhome were eventually sterilized. These four main feeder institutions had a different patient clientele (i.e. PTS and Deerhome were "homes" for younger patients, who were more likely to be diagnosed with some type of 'mental defectiveness', hence not requiring consent for sterilization after the 1937 amendment). What all this likely means is that in the early decades – the 1930s and 1940s, it was primarily mentally ill, older adults who were presented to the Board. They were able to exert some of their power by refusing to consent to sterilization. However, over the years, the institutions housing younger, mental defectives rose to the fore and presented the bulk of the Board's clients. In other words, there likely was something very different about patients exhibiting agency and those not doing so. The former were older mentally ill patients earlier on in the operation of the Eugenics Board.

Other instances of patients exhibiting agency also exist. The first obvious case occurs on September 14, 1934 when a patient "whose case was prepared for presentation to the Eugenics Board was not passed as the patient did not appear." This must have been a Mental Hygiene Clinic case, an instance where the patient was not institutionalized. This would explain the freedom of choice the patient exhibited by boycotting the meeting.

On November 26, 1936 we find that 17 male cases were presented, one of which was "passed, but operation not to be done *if* patient objects." (italics added) From this sentence we can infer that sometimes patients *did* exercise their right to object to operations. We see evidence of patient agency again on May 31, 1937: "There was some discussion in regard to the performance of the directed operation on patients who expressed marked opposition to being operated upon. It was agreed that such cases be referred back to the Board again. How does the Board deal with opposition on the part of patients? It returns them to the formalized, intimidating meetings and hopes to 'influence' them to see the error of their ways and concede. One can only wonder how much of this went on that was not recorded in the Minutes.

Race and Ethnicity: Defining the "Problem Population" as Unworthy of Consent and Power

In this first decade of operation of the Board, we also find instances of ethnicity-related issues in 20% of the Minutes. The first example occurs at the May 21, 1935 meeting. "In view of the number of deportable cases, among the patients presented to the Board, *many of whom refuse consent for sterilization*, the Board agreed that a recommendation be sent to the government, that steps be taken to deport as many as possible of these cases." Immigration, which is part of the construction of the problem in the public domain, also appears to be an issue for the Board. If these newcomers do not consent to what the Board thinks should be done to them, the solution is to send them back to their home country. The clause referring to those immigrants who refuse to consent implies that those who *do* consent to sterilization are welcome to stay.

The second example involves an "Indian" and his sterilization (meeting no. 83; May 31, 1937). What is interesting about this example is the involvement of yet another government department, the Department of Indian Affairs, and the comment this example makes on the relations between the Board, the Government and "Indians". It is worth discussing in detail because of the insight it provides into the 'official' construction (Government and Board) of native people, and likely other minorities as well.

The saga begins with a letter from the Department of Indian Affairs which notes that "while the Department *would not refuse to allow an operation for sexual sterilization* to be performed, in cases such as this, it directed that the patient's consent, and also the relative's consent be obtained, if this was at all possible." The Board responds to this letter by invoking the recent Amendment to the Act. Since the "Indian" in question is schizophrenic and mentally defective, the Amendment applies to him and as such renders his consent unnecessary. While this should technically be a clear-cut case of 'no consent required', the Indian Affairs Branch is particularly cautious, but not because of any humanitarian or legal issues.

> The Department has no power to authorize the sterilization of an *insane Indian*. It *has no objections to the operation*, and would regard it with approval if carried out in accordance with the laws and regulations of the Province. It cannot, however, agree that any Indian should be sterilized without the consent of his relatives, and of himself as well, if he is mentally competent to understand the results of the operation. *It is not beyond the realm of possibility that Indians might get an impression that there was a conspiracy for the elimination of the race by this means.* While, therefore, the Department can neither authorize nor forbid the operation itself, it is directed that the greatest care be taken that the Indian and his relatives be got to understand the reason for it, and that written consent be obtained before it is proceeded with.

Still pressing for the operation without consent, the Board responds by pointing out that the patient is not willing to consent, but "according to the present Alberta Sterilization Act, his consent would not be necessary." They do conclude their letter by stating that "notwithstanding this latter fact, it has not been our policy to operate where there are *extenuating circumstances, which in this case, would be the fact that he is an Indian*. No operation will be performed until I have further advice from your Department." Race and 'relations with Indians' appears to be a very sensitive area.

At any rate, it seems from the Minutes in the 1930s that what power the patients did have paled in comparison to that of the government-backed Board. The Board is concerned throughout the Minutes with administrative concerns and the miscellaneous matter of daily operations. This is the 'theme' we discuss next – the Board as 'business".

Administrative Procedures: The Board as Organization and Business

Tallies and Reports

One of the Board's main concerns was keeping tabs on the number of people being processed. From the organizational literature we know that one goal of nascent organizations is to illustrate the need for their existence, often through the use of statistics (Meyer and Rowan, 1977; DiMaggio and Powell, 1983). Numbers are a powerful means of summarizing one's efforts, showing progress, and establishing legitimacy. For these reasons, we should not find it surprising that early on in its existence, the Board was concerned with documenting its progress by reporting its work in tallies and reports. In fact, slowly the 'follow-up reports' discussed earlier were replaced with 'tallies' or counts on numbers of operations completed since the previous Board meeting. The first mention of a 'count' occurs at the March 15, 1934 meeting. However, this count is of those cases NOT operated on (work the Board must do). Discussion of tallies and reports of operations performed are found in 16% of the meetings Minutes.

On March 27, 1935, we see the presentation of a "report of the work of the Board up to 1933." The Board appears to be more and more cognizant of its role as an organization. As such the Board members are concerned with production reports. On September 30, 1936 "Dr. R. R. MacLean gave a report of operations performed to date, as follows: - Males.....149; Females.....297; Total: 446." Another such report is presented at the November 26, 1936 meeting and another at the October 13, 1937 meeting (in this report, the category of orchidectomies is added to the usual male/female tallies. Six such operations were performed in 1937.) On December 7, 1937, another report is presented (total for the year is 100 cases). It is at this meeting that the first steps are taken to initiate what becomes a standard practice for the Minutes of the Board meetings: attached is a separate sheet that summarizes sterilization operations that have occurred since the previous Board meeting. It appears that the Board was very concerned with its production and wanted at all times to keep track of its activities.

Finally, at the October 12, 1939 meeting we find the following, telling comment: "The Secretary presented to the Board members some follow-up notes on Eugenics Board cases, which were reviewed briefly; also a list of the 14 cases operated on since the last meeting in April, 1939. This brings the total cases operated on to 672, being 252 males and 420 female cases." What is so interesting about this quotation from the Minutes is that it represents a construction of the Board that occurred during the 1930s. What began as a seemingly caring and concerned Board has turned into a machine, a production line, a bureaucracy concerned with production numbers, tallies and reports on its own 'progress'.

In the initial meetings we can see from the Minutes that a fair amount of time and space was spent on follow-up reports. Social workers presented relatively comprehensive reports on the post-operative adjustment of patients. Now, in 1939 we have in the Minutes very brief mention of '*some*' (not all) follow-up *notes* (they once were referred to as reports) which were reviewed '*briefly*'. Much more time and space is spent on the 'list' of cases operated on since the last meeting and on the total cases operated on to date. As the Board becomes more established, one goal is to provide administrative proof of the need for the continuation of its work, and along with that, more resources to get the job done.

Conclusion

The Alberta Eugenics Board in the 1930s was eager to establish itself as a powerful influence and an effective and efficient extension of the Government of Alberta. We saw that it primarily concerned itself with the "consent" issue, which began as a concern for patients and eventually was transformed into the desire to get rid of the difficulties associated with attaining consent. The Amendment to the Act was ultimately the solution to this problem. We also saw that, in this decade, the power of the Board was established, particularly the power of the Chairman and several key individuals on the Board. Related to this was the distinct lack of power on the part of patients, especially those defined as "mentally defective", and those who were members of immigrant or "Indian" groups. Another theme concerned expansion, in terms of jurisdiction over increasing numbers of people, areas, and procedures. Finally, the Board was first and foremost a bureaucratic organization, an administrative body with a job to accomplish. As such, we see evidence in the Minutes of the administrative concerns of the Board: keeping track of 'work done' through the use of tallies and reports. We also see discussion of policies and procedures, and of course, a concern of most organizations, funding issues. We see below in our analyses of the minutes for the 1950s and 1960s, that many of these themes reappear, some in the same form, others with variations. The Board though, in terms of its concerns and operations as recorded in the Minutes, remained remarkably consistent.

Chapter 7

Well on Their Way: Minutes from the 1950s and 1960s

The 1940s and 1970s have been omitted from this analysis because these decades are different from the remaining decades. Specifically, these decades are different in terms of "production" (i.e., less presentations and sterilizations occurred). In addition, the 1940s include the war years, which may have impacted on the Board's activities. Also, time and space restraints made it necessary to focus the analysis. This Chapter focuses on the Minutes from the 1950s and 1960s. The Board's activities really picked up in the 1950s and the 1960s. There were two peaks in the Board's activities. One occurred between 1934 and 1939 and a second in 1958. Although the 1930s witnessed the highest number of presentations to the Eugenics Board (1470), the 1950s and 1960s combined saw 2034 cases presented. It was during these three decades that 3504 of the 4785 individuals ever to appear before the Board were processed.

During the late 1950s and the 1960s the Eugenics Board started approving more people for sterilization and it also began sterilizing more patients at a younger age. Part of the reason was the increased activity at the Provincial Training School in Red Deer. "Business" at this institution really increased during these decades, particularly the late 1950s and the early 1960s. Since it seems unlikely that there was a sudden increase in the number of people who were "defective", it is more probable that something changed in either the manner in which the institution(s) were run, or in the way patients were processed by the Board, or maybe a combination of both.

The Minutes of the Alberta Eugenics Board for the 1950s are analyzed in this chapter. Themes that emerge during this time period are compared with the themes from the 1930s discussed above. Next, the Minutes from the 1960s are analyzed and comparisons between and within decades made.

What becomes apparent after reading the minutes from the 1950s is that, for the most part, the same general themes appear. The initial concerns of the Board remained concerns in the 1950s, although the specific form of these concerns did change somewhat. Interestingly, in 63% of the meetings for this decade the only business conducted at the Eugenics Board's meetings was the presenting and passing of cases. In other words, the Minutes list only the attendance of people present at the meetings, the names of patients presented and the decision of the Board regarding sterilization[5]. This indicates that the Board's activities during the meetings had, by the 1950s, become 'streamlined' and efficient. The Eugenics Board met to see and pass cases for the most part. Other issues were secondary to this role.

The Entrenchment of Power

One of the main themes that emerged in the 1930s and that remains in the 1950s is that of power - power of individual Board members, power of the surgeons, and power of the Board in general over the people it controlled. In the 1930s the Board emerged as a confident group determined to get its job done. Individuals on the Board also emerged as able and willing to exert the power invested in them through their association with the Alberta Eugenics Board. We saw evidence of surgeons bargaining for power and money, as well as a monopoly over sterilization operations. We saw evidence of a very powerful and influential Chairman of the Board. In addition there was some evidence of sterilization decisions being left up to individuals during times of emergency or when it was not efficient to gather as a group to make decisions. This behaviour continued in the 1950s. Such 'power' issues emerged in 48% of the 98 meetings in the 1950s.

Surgeon Power, Discretion and Control

In the 1950s, as compared to the 1930s, we see many more operation stipulations in the Minutes that leave decisions to the "discretion of the surgeon." Often we read that a patient is to have a salpingectomy (tubes tied) or oophorectomy (ovaries removed) "at the discretion of the surgeon". This is a major surgical decision, the two operations are quite different in terms of effect and intrusiveness. At the September 11, 1958 meeting for one female patient it is written: "Sterilization – preferably Hysterectomy or Oophorectomy at the discretion of the surgeon". What were the criteria for the surgeon's decision? Does it depend on something that appears to the surgeon as he operates? Does it have to do with anatomy? Ease of procedure? How does this discretion relate to the person's level of mental

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[5] There are some instances of overlap with other themes. For example a patient might have expressed opposition at one of these meetings.

'defectiveness'? At any rate, the surgeons were given the power to decide, at the time of operation, whether a woman's tubes should be tied or whether her ovaries should be removed.

One male case was "passed clear" at the January 20, 1950 meeting with the "recommendation that the surgeon be consulted regarding the advisability of left orchidectomy for therapeutic purposes". These are major life-changing decisions. Nowhere in the Act are surgeons invested with such power. The Board was clearly acting on its own. At meeting No. 158 (January 20, 1950), two cases were "passed subject to surgeon's approval". Again, it appears that surgeons had a lot of power to make decisions. In this case, the decision was whether or not sterilization would occur. Why do we have a Board, invested with the power of legislation to make these decisions, if it is going to defer this decision-making power and responsibility to an individual? It may be that as the medicalization of this problem became more accepted, members of the medical profession gained more power and authority in making these types of decisions.

A different type of power-flexing occurs at meeting no. 164 where the issue raised has to do with the even distribution of cases between surgeons. Someone must have been complaining about not getting a big enough or fair enough share of the pie. Specifically,

> Dr. Selby and Dr. Thomson brought up the question of whether or not the surgical cases were evenly distributed between the Surgical Consultants, and it was decided to investigate the matter. In the future the Surgeon's name will be placed after the name of each patient on the list of "Eugenical Operations Performed Since the Board's Last Meeting" for ready reference in determining how the operations were distributed between the Surgeons in question.

There is an effort here to keep the surgeons happy, perhaps because of their growing status in the medical community but also because the Board members needed them to continue with the eugenics process. It is also interesting to note that in 1958 (meeting no. 233, January 10), a recommendation was made regarding surgeons. "It was decided that in the future, recommendations regarding the appointment of Surgeons to the Board would be made on the understanding that such appointments would terminate at the end of the 65th years of age of the Surgeons concerned." This recommendation can be interpreted in two ways. The first would be that it is restricting, a flexing of the Board's power over surgeons. However, another way to interpret this is that once appointed, the surgeon has guaranteed work for life (or at least until retirement). In this sense, it is giving the surgeons power and steady employment.

Another example of the monopoly the surgeons had and the way in which they protected this monopoly appears at meeting no. 166 (November 16, 1950):

> Dr. R. K. Thomson brought up the question of the possibility of the operations of cases seen and passed by the Board being performed by Surgeons selected by the parents or guardians of the cases concerned, and at Hospitals considered by the Surgeons and relatives to be satisfactory, this procedure to be carried out at the expense of the parties concerned. The Board decided that for the time being at least, such a course of action would not be advisable.

Here we have a situation where the Board (and government) would be able to save money (parents pay for operation). This would also solve the problem mentioned later on in the Minutes where a concern is raised about accessibility/availability of surgeons to perform operations at the Provincial Mental Hospital, Ponoka (discussed below). Yet, the Board is reluctant to involve other surgeons and hospitals in its business.

An interesting situation in 1950 concerned one of the surgeons to the Board. Dr. Vant had been required to perform emergency abdominal surgery, an operation he did not feel qualified to perform. There were letters exchanged regarding this matter, with Vant threatening to resign if he was ever required to do general surgery again. The conclusion reached after this threat was leveled at the Board was as follows:

> the Secretary was instructed to write to Dr. J. Ross Vant and inform him that in future, as far as the Eugenics Board is concerned, it would expect him to perform only the operations ordered by it, and that any arrangements which might be made for the Surgeon to do any other types of operations would be a matter strictly between the Surgeon and the Medical Superintendent of the Institution concerned... .

This particular surgeon was able to dictate to the Board the specific types of operations that he felt he wanted to do for them. The Board seems to have wanted and/or needed this surgeon's services enough to give him what he wanted.

At meeting no. 220 (November 30, 1956), a discussion regarding surgeons comes up again. It was decided that the Board "should approach the Minister of Health with a view to working out arrangements whereby the services of qualified Surgeons more accessible to the Hospital might be obtained… ." There was also an effort to increase the number of surgeons available to serve the Board. There must have been an increasing demand for their services. In other words, the surgeons available could not keep up to the workload. An example of this is discussed at the May 22, 1959 meeting, where it came to the Board's attention that one of the surgeons apparently could not make his appointments to conduct four vasectomies at the Provincial Training School. Instead of canceling, he found a different surgeon (one not affiliated with the Board) to perform the operations. "The Board discussed this irregularity and it was decided the Chairman would call it to the attention of the Honourable the Minister of Health." This surgeon (Parsons) violated all official documents (which state which surgeon is to operate and when) by taking the action he did.

Although the Board-appointed surgeons clearly are gaining power, the fact is that the surgeons are employed by the Board. Attached to the March 24, 1959 minutes there is a note which says the following: "Mrs. James – Re: The surgeons. They are surgeons to the Board according to the Sterilization Act. They are also consultants to the Hospitals and [Training] School but their duties in this regard lie outside their duties as far as the Board is concerned. J. M. MacEachran." For whatever reason, maybe conflict over jurisdiction of surgeon activities, this fact needed to be reiterated and made clear. At any rate the alliance between Board and surgeons appears to be one where, although the surgeons ultimately answered to the Board, they were able to exert their power. They, after all, were providing a valuable service to the Board.

Board is Boss: The Power of Individual Board Members

The Chairman of the Board who emerged in the 1930s Minutes as an influential individual continued to reign over the Board, its affiliated institutions, and its patients. During the 1950s we see that individual Board members were granted a certain degree of power. I have also suggested that some surgeons become more powerful over time. Who else gained in authority and power? As the medicalization of the social problem progressed, individual Superintendents of institutions played a more important role in the meetings and activities of the Board.

Superintendents

Knowledge and control over certain types of knowledge is power, particularly in the case of members of the medical profession making decisions regarding their patients and withholding information from these patients. We see this illustrated very well in the operation of the Board.

> The Medical Superintendent of the PMH, Ponoka and the PTS, Red Deer, consulted the Board with regard to whether or not it was advisable to discuss with the patients and/or the parents the matter of the patients' operations for sexual sterilization, after the Board has passed the cases "Clear', for the operation, and before the operation was performed. *The Board ruled that the Superintendents should decide this question themselves, on the strength of their knowledge of the individual cases and the parents concerned. This would also apply to the question of whether or not the operation itself should be performed if the patient and/or the parent objected to it"* (italics added).

The decision on the part of the Board gives the Superintendents a great deal of power: power to inform patients and/or parents of plans for sterilization, power to essentially decide what is best for the patient and his or her family. By having control over this knowledge, the knowledge that the patient is slated for sterilization, the Superintendent holds the patient's future in his hands. By controlling this information and deciding whether or not it should be shared, the Superintendent has control over the patient's agency. However, it does not end here. The Superintendent is also given the power to control potential patient and/or parent objection to the surgery. By withholding such information (that the patient has been 'passed' for sterilization) from the people involved, the Superintendent can avoid potentially problematic situations. The Superintendent can decide whether to share the information regarding the Board's decision. But the Superintendent can also, in the face of adamant objection from patients or parents, prevent the patient's sterilization. In other words, the Board makes a decision to sterilize, but the Superintendent can override that decision if patient or parent objection is such that not performing the operation would be in the best interest of the Superintendent. The Board has essentially given these individuals the power to act on their own, either in support of or against the decision of the Board! It is interesting that the Superintendents, who are the mental health experts, are assigned the task not of determining whether the patient is feebleminded and requires sterilization, but rather whether and how consent issues should be dealt with.

Dr. le Vann: The "Convincer"

While it is not my intention to single out any particular individual as a scapegoat in discussing the activities of the Eugenics Board, Dr. le Vann cannot evade discussion. His name enters the Minutes repeatedly throughout the 1950s. It may not be coincidental that the Provincial Training School, of which he was Superintendent during this time, saw a significant increase in presentations and sterilizations during the 1950s and 1960s. On February 9, 1951, the Board had to rein him in. It appears that le Vann wanted to present and sterilize *children*.

> In reply to a question put to the Board by Dr. le Vann, the Board gave it as its considered opinion that it is preferable to wait with presenting cases until they reach adolescence. This is because of the fact that it is felt that the sexual tendencies of those presented may be better evaluated at that time. In cases where the trainee is to be discharged, the Board is of the opinion that these could be presented before discharge.

This last comment about presenting patients before discharging them might be one of the reasons for the increase in cases presented and sterilized by the PTS. This may have been le Vann's loophole for presenting more and younger patients. At any rate, he appears from this quote to have been eager to get the job done. So eager, that the Board itself had to put restraints on him.

After this first entry, Le Vann's name enters the Minutes repeatedly regarding another issue: 'convincing' recalcitrant parents to give consent for the sterilization of their children. The first example of le Vann asking the Board for help in these types of matters occurs on November 16, 1950, where we find the following entry in the Minutes:

> Correspondence in respect to [patient name]… was read. This was to the effect that the patient's father was very much opposed to the operation for sexual sterilization being performed on this patient. Dr. L. J. le Vann, Medical Superintendent of the Training School, requested that the Board direct him in the handling of this problem. After considerable discussion it was decided by the Board that Dr. le Vann *should attempt to convince the patient's father* that

> the operation should be performed before the patient was discharged from the Training School. *In the event that he insisted on taking his son from the Training School without the operation having been performed*, the former *should be made to understand* that *he would be entirely responsible for any difficulties* the patient might get into because the operation had not been performed… (italics added).

The first time that le Vann approaches the Board regarding the proper procedure for handling this type of consent issue, he appears to be encouraged by the Board to apply pressure to the father of the patient, to "convince" him with what appears to be a threat (responsibility for future difficulties). We find out at a later meeting (February 9, 1951) that le Vann effectively resolved the situation: le Vann sent a letter to the Board "in which he stated that the father of this boy had now consented to having the Eugenical operation performed upon his son."

Le Vann, having completed his first assignment successfully, seems to almost relish his role as convincer and persuader. In the minutes for November 21, 1952 we read the following:

> The case of… presented to the Eugenics Board on April the 4th, 1952 and Passed Clear for Salpingectomy, was brought to the Board's attention by Dr. L. J. le Vann and Dr. T. C. Michie. Dr Michie stated that the father of this girl had insisted upon removing her from the PMH before the operation for sexual sterilization was performed. Dr. le Vann informed the Board that [the patient] had been admitted to the PTS on Oct, 28th, 1952. Dr. le Vann requested that the Board direct him in his handling of the situation insofar as to whether or not the operation should be proceeded with in view of the father's continued objections. It was suggested to Dr. le Vann *that another attempt be made to persuade the father to agree to the operation.*" (italics added).

Again, at any sign of opposition to the operation, the parents must be *convinced* of the value of having their child operated upon. We certainly do not see this kind of convincing occurring the 1930s. In fact, the 1930s was a decade during which the Board, for the most part (certainly up until the amendment to the Act) was very concerned with consent issues and the welfare of the patient. Several cases were discussed in the 1930s where any hint of opposition on the part of family members meant not operating and not discussing it any further. Now, in the 1950s, we have active convincing and persuading which at times seems to border on threats and harassment.

Sometimes the Board resorted to intimidation. The following case illustrates the subtle use of intimidation on the part of the Board and le Vann:

> The case of [patient name] presented to the Board on December 9th, 1955, and "Passed Clear" for Salpingectomy, was reconsidered and re-examined, because a letter had been received by the Medical Superintendent of the Training School, from the mother of this trainee, stating that she objected to this procedure being carried out. After careful re-consideration of the case, the Board *suggested to the Medical Superintendent that he write to the mother of this trainee and inform her that he would be glad to discuss her daughter's case with her should she be able to visit the Training School*, but that the *Board was unanimous* in its opinion that the Salpingectomy should be performed before [patient's] discharge from the School (italics added).

This case is obviously similar to the others discussed above regarding parental objection. It differs though in the solution to the 'problem', and more importantly, in the content of the communication. This case is rich with subtle yet intimidating nuances. This mother wrote a letter expressing her objection. How many parents during this time could or would be able to write a letter of objection? Or would even think of writing to object? Also, the mother is invited to the institution to sit down and discuss the case with le Vann. Aside from his ability to convince people, Dr. le Vann was an educated man. She was a woman in the '50s, likely without the benefit of a university education. The power differential in this instance would definitely benefit the Superintendent. Also related to the power issue is mention of the 'unanimous' decision of four Board members. This is a subtle but convincing point. After receiving this letter, the mother might start questioning her own judgement in the face of all this professional opinion. "*Four* educated people who have seen cases like this since 1929 think my daughter should be sterilized – they *must* be right!" Again the issue of power and knowledge enters the picture here. This time the knowledge and power are being used to exert pressure on the mother to consent to the sterilization of her daughter.

The Board of course has the power invested in it through legislation to make sterilization decisions. But at the October 29, 1959 meeting there is evidence of more coercive power. This is an example of the lengths to which the Board would go to have someone sterilized. Essentially what happened is two women were seen at a Guidance Clinic and both agreed to appear before the Board. They were to be accompanied by two social workers. When the women did not show up for the meeting, the social workers presented their case to the Board.

> The Social Workers wished to find out if there might *be any way to "force" the women* in question to come before the Board, and, if the Board should so direct, have the operation for sexual sterilization performed. The board perused the histories of the two *Negro women* in question and *agreed that neither would appear to be suited to motherhood*, (each having had four illegitimate children for whom they are unable to adequately care) but could offer no solution to the problem of bringing them before the Board. The Board informed the Social Workers that the Minister of Public Health did have the *authority* under *Section 6 of the Mental Defectives' Act* to cause proceedings to be instituted before a Justice of the Peace in order to have cases such as this placed in an Institution. It was also suggested that if either of *these women ever became involved with the Law it might then be possible to have her admitted to one of the Provincial Mental Institutions and brought before the Board"* (italics added).

This quote contains much information concerning the construction of feeblemindedness on the part of the social workers and the Board. The mention of illegitimate children provides evidence of the Eugenics Board's concern with promiscuity and illegitimacy, which for the Board members seem to accompany each other. I return to this issue in a later chapter. As well mention of these women's ethnicity provides support for some of the race issues regarding sterilization which we will also see more of later. But particularly relevant to this discussion is the apparent willingness of the Board to invoke the *Mental Defectives Act* to have these women forcefully confined and then forced to appear before the Board even though there is nothing mentioned about their mental capacity. Also, there is a hint that they expect these women to get into trouble with the law, and then they will definitely be forced to come under the jurisdiction of the Board. At any rate, the Board is well aware of, and very prepared to use the avenues available, to coerce potential clients to appear before them.

Consent Issues

Perhaps the most common theme in the minutes during the 1930s was that of consent. The Eugenics Board was consumed by this issue, attaining consent appropriately, making sure it was legal, debating it, turning to multiple sources of consent, and eventually playing a role in initiating the amendment to the Act that removed the consent stipulation for certain categories of people. Although there are many common themes in the Minutes from the 1930s, and the 1950s, the Minutes for the 1950s indicate a definite change in the approach to consent. This is one area where the Board experienced a change in policy and practice. Of course, the amendment that removed the consent requirement has already been in place for 20 years. So, initial consent concerns are a distant memory. If the 1930s can be characterized by a concern for consent and the patient, the 1950s can be characterized as having a definite lack of such concern. Consent concerns, in terms of the frequency with which they are recorded in the Minutes are reduced from the 64% we saw above for the 1930s (remaining Minutes after the initial thirty meetings) to 26% of meetings in the 1950s. We saw above the manner in which the Board and le Vann, did everything within its power to coerce consent. We saw some "convincing" occurring that reinforced the idea of the Board as being all-knowing and all controlling. Patient agency is seldom recognized and when it is, every attempt is made to quash it.

An interesting effect of this attitude toward consent is the proposition and implementation of a new type of administrative form to be used by the institutions. This form, filled out on admittance to the institution, amounts to consent to sterilization. The discussion at the meeting on September 23, 1955 went as follows:

> A form, such as the attached form in respect to sexual sterilization, was discussed, and while the Board acknowledged the value of this form, it was generally agreed that the same purpose would be accomplished if at an appropriate time, upon or following the admission of the child, the question of sterilization and the legislation at present in existence in the Province in respect to it, might be discussed with the parents or guardians, and a written note of their reactions to the whole subject entered into the Trainee's file.

The form discussed reads as follows:

"Provincial Training School, Red Deer, Alberta
I understand that in accordance with the Alberta Statutes my child will be presented to the Provincial Eugenics Board, and that if they deem it advisable he will subsequently be sterilized. Signed: Date: Witness:"

Essentially, upon admitting their children to the institution, the parents signed a consent-to-sterilization form. Interestingly, this form makes no mention of feeblemindedness as a reason for presentation to the Eugenics Board. This procedure has come a long way from the 1930s. The efficiency is remarkable. There is evidence that use of this form was implemented.

Related to this issue is the concern that certain Superintendents (Dr. Michie and Dr. le Vann; meeting no. 181, November 21, 1952) had about the necessity of consulting with parents of mental defectives before sterilization occurred. The Board reiterates its decision from a previous meeting that the individual Superintendents must decide for themselves how to deal with this issue. This is an interesting entry into the Minutes. It raises some important questions. Why are the Superintendents concerned with consent or rather consultation with parents of mental defectives? According to the Amendment of the Act in 1937, mental defectives no longer are required to consent to sterilization. Technically, the Superintendents do not have to tell the parents what is going on with their children. Could it be that parents are complaining and giving the Superintendents trouble over the sterilization of mentally defective children? There is no explicit statement in the Minutes on the reason behind this concern, so we are led to alternative interpretations. It may be that parents were raising questions with the Superintendents or alternatively, that Superintendents themselves had ethical concerns with what was essentially legal procedure.

We also see instances of the Board changing its decision regarding patients. On January 20, 1950, Dr. Michie brought up a case from a previous meeting for discussion. He "requested that the Board's decision in her case be changed from 'passed clear', to 'subject to consent of patient'. The Board consented to do this." We have no explanation for why this change was made. We are left, however, with the feeling that maybe the Board's decisions are not as definitive or unquestionable as they have led us to believe. This is an example of the possible realization on the part of the Eugenics Board that consent might be worth obtaining for some patients, and that perhaps they were prematurely passing patients clear.

There is also evidence in the Minutes from the 1950s of the Board waiting until a patient becomes an adult, a time when it will no longer need parental consent (no. 202; April 1, 1955). This happens several more times throughout the decade; it is a legal way for the Board to circumvent consent requirements. They patiently work around the stipulations in order to attain the sterilizations they want done.

Working Around Deferrals

Not only does the Board patiently wait for patients to come of age so that parental consent can be avoided, there is also evidence of them looking for ways around deferrals. We see an increase in the amount of testing going on in the 1950s. And specifically related to this point, the testing seems to occur as a way of attempting to see if the patients have deteriorated in any way.

> [Patient's name] was also presented to the Board, but because her case does not come within the Sexual Sterilization Act she was given the deferred number indicated above. The Board recommended that this girl be given another Psychometric examination, *with a view to determining whether or not her intellectual status had shown any deterioration* since she was last tested by the Provincial Guidance Clinic Staff in 1949 (italics added).

At another meeting (no. 174, October 3, 1951) the same type of thing occurs: "This case was given careful consideration and it was decided that at *the present time* her Diagnosis and Intellectual rating prevented her case from falling within the scope of the Sterilization Act." Most deferred cases had the following reasoning as an explanation: "this case does not *at this time* fall within the Sexual Sterilization Act" (italics added). We get a sense that there is "hope" that either the Act will be amended to include such cases in the future or that maybe with time the patient will regress and then fall under the jurisdiction of the Board.

The following case is an excellent example of the persistence with which the Board operated in attempting to get the results they wanted. They manipulated all the tools at their disposal in order to get the job done. "Passed subject to consent of patient with the condition *that if upon recovery consent is not given, the patient should be re-tested* and, *should the psychometric examination indicate mental deficiency,* the patient then be *re-presented* to the Board *prior to discharge*" (italics added).

We also find another case where the patient's diagnosis has actually changed so that sterilization is made easier: "The Board was asked to re-consider this case since he is now diagnosed as being Mentally Defective. At the time of his original presentation to the Board his diagnosis was considered to be Schizophrenic – Catatonic type. In the light of the new diagnosis this case was PASSED CLEAR –

Date of first presentation was December 19, 1939." Could the Board be manipulating diagnoses now in order to get patients "processed" quicker and with more ease? Its close affiliation with the Superintendents of the institutions certainly would not preclude this type of "collaborative" behaviour.

The Use of "Tests"

The Board's extensive use of testing is apparent throughout the Minutes of the 1950s. What is shocking is that at the November 27, 1958 meeting they finally request "that a Psychologist attend the Eugenics Board meetings for the purpose of interpreting the various Psychological Test results for the Board." If one takes this as an admission of ignorance regarding the interpretation of such tests, the use of these tests up to this point becomes questionable. It should be mentioned that le Vann has always had in attendance the Training School Psychologist when meetings were held at the PTS.

What are the implications for the construction of this social problem of feeblemindedness? It appears that the Board's construction was only partially based on medical and scientific evidence (intelligence tests), but also on something else, since it appears that the test results were not fully accessible to the Board, at least not until the late 1950s.

Surgical Mistakes

The Board experienced problems not only with the interpretation of test results, but also with the performance of operations. Specifically, there were some operations not completed correctly. The first such instance was reported at the September 20, 1957 meeting where we find out about such a botched operation.

> The case of [patient's name] was brought to the Board's attention by Dr. T. C. Michie, because of the fact that although an OOPHORECTOMY had been performed upon this girl, at the Board's direction, the continuation of menses indicated that *the operation had not been complete.* The Board, after careful consideration, directed that *another attempt* be made to remove both ovaries, and *as a precautionary measure, a salpingectomy be performed at the same time...* (italics added)

The following also appears in the Minutes of this meeting: "Although the above instance is the only one which has occurred in connection with Alberta Eugenics cases, the Board ruled that as an added precaution, in the future all cases passed for Oophorectomy should also have Salpingectomies performed."

Lest we mistakenly believe that this was a one-time incident, another case appears where an operation was not performed correctly. At the March 25, 1959 meeting we find out about a case where there are "indications that she may be pregnant, although a Bilateral Salpingectomy was performed upon her on July the 30th, 1943." Granted there are only two such cases recorded in the Minutes, so it would be unfair to conclude that the surgeons were generally negligent. Worthwhile to note is the Eugenics Board's stance on this issue. They are concerned not with patient welfare but rather with ensuring that successful sterilization occurs.

In terms of surgeon responsibility, this carelessness makes one wonder too about the testicular biopsies that continued to be performed well into the 1950s. We are never informed of why they are being done. In one case the biopsy is done for "therapeutic purposes".

The Board Continues to Push for More Amendments

Expansion of Act

As with the Minutes of the 1930s, there is a sub-theme of 'expansion' in the minutes of the 1950s. The expansions are in many ways similar to the types of expansion that were occurring in the formative years of the Board. In the 1930s, there was an attempt to bring more people under the jurisdiction of the Act. This also occurs in the 1950s. The theme emerges in only about five of the meeting minutes, but is worth mentioning. Specifically, one family was the cause of this newest concern with expanding the scope of the Act. Their case is discussed for the first time at the April 13, 1951 meeting.

> Dr. E. R. Selby discussed with the Board the possibility of sexual sterilization for two of his patients of the [family name] family, who wished to have the operation performed because, *like most members of their family, they are afflicted with deformities which appear to be of a highly transmissible nature.* It was decided that when Dr. Selby had obtained specific data in respect to these cases the matter could be taken up with the Minister of Health, and *an effort made to obtain special Legislation to deal with cases such as these, who do not fall within the Sterilization Act* (italics added).

The case is discussed again on October 3, 1951.

> In connection with the legality of sexual sterilization under the Sterilization Act, in so far as the [same family name as above] cases are concerned – Dr. R. R. MacLean reported to the Board that he had discussed the matter with the Minister of Health. On the Minister's advice Dr. MacLean had consulted with officials of the Alberta College of Physicians and Surgeons. Dr. MacLean stated that the latter Organization could find nothing in its Constitution relative to sexual sterilization. The Board then requested that Dr. MacLean take the matter up with the Attorney General's Department, in an attempt to get a legal opinion concerning these cases, after which the matter could again be referred to the Department of Health. Dr. Selby stated that there was some urgency in getting the operations performed, *as frequent conceptions occurred in the various branches of the [family name] family, which almost invariably* resulted in *deformed progeny*.

The Board is intent on attaining a legal ruling, if not an amendment to the Act, regarding these cases. The significance of this case, aside from the persistence and determination of the Board, is that they are trying to get a ruling on "physical deformities". The comment on "frequent conceptions in the various branches" is reminiscent of Dugdale's pedigree charts. The Board is trying to move beyond its jurisdiction over mental afflictions (and morality) and is now entering the realm of the physical.

We see more discussion of this issue during later meetings until it is put to rest on February 8, 1952 with the following statement: "The question of amending the present Sterilization Act so that it might include *hereditarily deformed persons*, such as members of the [same family], was again discussed. Dr. R. R. MacLean reported to the Board that he had gone into this matter with the Departmental authorities, who did not deem it advisable to re-open the Sexual Sterilization Act at this time." (italics added)

There is also mention of further amendments to the Act at the March 25, 1959 meeting. Here "a lengthy discussion was held in connection with the obtaining of an amendment to the Sexual Sterilization Act which would permit of the sterilization of *potential* cases of Huntington's Chorea, subject to their own consent" (italics added). The Board had found another hereditary disorder to include in the Act. However, we are again dealing with the "potential" of the disease to be transferred to offspring, a difficult thing to predict.

Funding Issues and Miscellaneous Administrative Items

As with the minutes from the 1930s, those from the 1950s also include frequent mention of funding, wages, and staff shortages. Mention is made again (as in the 1930s) about the need for a full time social worker so that follow-up reports can be conducted. There is also talk of increasing the honorarium of the Visiting Board as well as combining the Visiting Board with the Eugenics Board.

The "usual" administration concerns occur during almost every meeting. There is consistent talk of Visiting Board schedules, the scheduling of the next Eugenics Board meeting, as well as personal notes, congratulatory messages, condolences, and announcements of new additions to the Boards and/or meetings. Also, there are the ever-present lists of operations performed, a more refined form of the raw tallies that were used in the 1930s. Also evident are two formal complaints from people who have been sterilized and are not happy about it. In one instance the Board is forced to discuss the legality of the sterilization. There are no thank-you letters as there were in the 1930s, and certainly not the correspondence in support of the movement that also was frequently appended to the minutes in the 1930s. This is interesting. In the 1930s, the Board was responding to concerns raised in the public, concerns brought to the fore initially through the activities of claimsmakers, but still, the public supported eugenics. However, despite the lack of interest on the part of the public, the Board continued its activities.

Conclusions

How do the Minutes from the 1950s compare with those from the 1930s discussed earlier? Some of the similarities and differences have been outlined above. Many of the same types of themes emerged: concern with expansion, power issues, consent issues, and administrative concerns. However, the specific nature of these topics is somewhat different for the different decades. The result is a significant change in the Board in many respects. The 1930s were formative years. In many ways the Board and the surgeons were establishing procedures and carving a niche for themselves. People were trying out different roles and tactics to see what would work best to solve the problem of feeblemindedness. Surgeons during the 1930s were working on establishing their roles in the process. Board members were very cautious when it came to consent issues. We saw a constant turning to the Attorney General's Department and the Minister of Health for advice on cases. There appeared to be much more concern for patients in the 1930s. More time was spent on each case. Even follow-ups reports were given attention during this decade. We saw hints of patient agency during this time period -- patients and/or their families expressing opposition to sterilization. Often their beliefs were respected. Many cases requiring consent were simply dropped when consent was not attained. It is true that the Amendment regarding consent occurred during this decade, but overall, the impression we get of the Board during these initial years was that of a newly organized group with cautious ideals.

The Eugenics Board of the 1950s leaves us with the impression of a machine that has been perfected in terms of its efficiency, a machine that has become unfeeling and unbending, with little concern for its patients, a machine concerned with getting the job done and getting it done no matter what it takes. The process has been perfected: production has increased, dissent has been eliminated. We are dealing with a much more experienced Board during this decade. There is little patient agency, or at least no talk of it (except of course for the cases who were not sterilized). Any opposition is eliminated by the Superintendent of the decade -- le Vann. Even deferrals are not accepted as definitive. There is a feeling of optimism that the patients, if retested, might show regression to the extent that the deferral will be null and void. The Board has given surgeons power to make decisions regarding types of operations at the time of surgery. It is recommending hysterectomies and oophorectomies, operations that do more than 'simply' sterilize women. In the 1930s there were no such operations directed by the Board. By the 1950s, 34 hysterectomies or oophorectomies had been directed. The 1960s witnessed the direction of 32 such operations. The Board also directed the performance of testicular biopsies. While there were no testicular biopsies directed during the 1930s, in the 1950s eighteen were directed and in the 1960s eleven were directed. This type of experimentation goes above and beyond the scope of the *Sterilization Act*. We now have a confident, powerful Board. There are now special "consent" forms filled out on admission to a provincial training school. Parents might sign/consent thinking that this is just procedure and that the chances of their child being sterilized are slim. By the time the child might be operated upon they will likely have forgotten that they consented.

What are the implications of these changes for the Board's construction of the problem of feeblemindedness? It appears that the construction of this social problem has become a business for the Board. Fading into the background are initial concerns with publicity campaigns, public relations work, and educational and research links. The Board no longer seems concerned with the 'eugenics movement' as such. And correspondingly, the public seems less concerned with the Board's activities. Rather, the Board's concern is with getting the job of sterilization done efficiently and with as little resistance as possible. We have an image of a machine, a bulldozer, doing its work without stopping to check or question what exactly it is it is doing.

What does this mean for the social construction of the problem? The Board has expanded the range of people who should come under its control. It is pushing for sterilization of people not within the jurisdiction of the Act. It is disregarding opposition to its activities. It is minimizing the agency of those people unfortunate enough to come under its influence. The Board has let its power 'go to its collective head'. We now turn to an analysis of the Minutes from the 1960s to see if these trends continue.

The Fourth Decade of Sterilization: Minutes from the 1960s

Pushing the Limits of the Sexual Sterilization Act: The Expansion Continues

As the Eugenics Board of Alberta entered the '60s, there was some variation on the themes from earlier decades, however for the most part, the same issues surfaced. One of the observations made earlier concerning the Minutes from the 1950s was that that decade was a very busy one for the Board and the institutions. Presentations and sterilizations both increased. This trend continued into the 1960s. In this decade, during 54% of the meetings, all that occurred was the presentation of cases. This is down slightly from the 63% we saw in the 1950s. This compares to only 30% for the 1930s.

People were being referred for sterilization when it was clear that they were outside the influence of the *Sexual Sterilization Act*. It was as if both the Board and the institutions were attempting to push the Act to the limit, to try and push through people who were clearly outside their jurisdictions. This type of behaviour was recorded in 35% of the 121 meeting Minutes for this decade.

Institutions

The institutions were making absurd referrals to the Board that seemed to end up wasting everyone's time. At the May 27, 1960 meeting the case of a girl from British Columbia was discussed. The end result? "Dr. Michie was advised that the Board had no jurisdiction in respect to residents of Provinces other than Alberta." This seems fairly obvious, since the *Sexual Sterilization Act* was a provincial statute. This happened again at the June 20, 1963 meeting where another case was "deferred because the patient is not an Alberta resident and the parents do not reside in Alberta."

There were also many more deferred cases in the 1960s. These cases, it seems from the Minutes, were weak cases, weak enough that the institutions should really have known better than to present them. One case presented on February 10, 1966 was deferred with the order that "a psychometric is to be done". Why was this patient presented without the test results? Is this just sloppiness on the part of the institutions? Again, it seems like they were pushing of the limit of the Act. Or perhaps they hoped that somehow the Board would be negligent and pass these cases without the proper information.

The first such case appears at the June 3, 1960 meeting, where one of the female cases was deferred. "This case was given careful consideration, but in view of the fact that she was neither psychotic nor mentally defective, her case was 'deferred' until such time as her condition might warrant re-presentation to the Board." In other words, there was no reason for this person to have been presented. She was neither psychotic nor mentally defective! Why was she being presented? These criteria for presentation are clearly laid out by the Act. The institutions have been referring people for the past 30 years. It seems odd that they forgot what types of people should be referred to the Board. On the other hand, there might be new staff working in the institutions, staff who are not aware of the criteria for presentation but who assume that sterilization is a good thing and must be attempted.

Another case like this appears at the September 9, 1960 meeting: "this case was deferred because of insufficient evidence of deficiency". There are several more instances (six at least) of these types of cases being presented and then being deferred. These cases indicate an eagerness (or desperation) that did not exist previously. The institutional construction has changed, whether intentionally or not, so that now 'normal' people are being pushed into the meetings by the institutional staff.

Testing and Manipulation

In the 1960s, the Board also seems determined to bring more patients under its domain. It seems as though the Board is determined to get the test results it wants, even if it means testing and re-testing patients. The Board goes back to past cases, in this case, eleven years prior, to re-test them and look for deterioration. One female was re-presented as a result of new test results:

> Originally presented on January 20, 1950, at the Provincial Mental Hospital, Ponoka, at which time her intellectual level had not been clearly established and she was passed subject to her own consent. She was re-presented today (Sept. 21, 1961) because a psychometric test performed on June 20, 1961, gave her an intelligence quotient of 57, with the result that a new diagnosis of "Mental Deficiency" was made. With this information available the Board was asked to re-consider the case with the following result: passed clear for salpingectomy.

Two other cases are worth mentioning here as examples of the Board's eagerness to find patients. One male case was deferred on April 19, 1966, with the instruction that he "be rechecked and a psychometric done". The second case, from the December 14, 1966 meeting, is that of a male case who was 'passed clear' but with the "request that another psychometric be done". Why has the Board passed someone clear when they are unsure about the test results?

The Board is optimistic that deferred cases will eventually be passed. This quote is telling: "Case deferred because the Board felt she *did not fall within the scope of the Sexual Sterilization Act* with the information available. She, or her husband, might be presented at a future meeting with *further evidence*" (italics added).

The Board not only constructed the problem and based their decisions on what they thought were facts, they also seemed to encourage some creative modifications of evidence in order to get patients passed for sterilization. Here is an example of this behaviour (this quote comes from a letter attached to the June 20, 1963 meeting. The letter is from the Board to the Superintendent of the institution where the patient resides):

> Re: [patient name] Diagnosis: Borderline I.Q. – Schizoid Personality. At the time of the Eugenics Board meeting at your Hospital on June the 20th, 1963, the above-mentioned young man was presented to the Board. Because of the diagnosis as noted above, the Board was not able to pass his case unconditionally, and I was instructed to advise you as follows: "It is a clinical impression that this patient *probably* has epilepsy on a background of schizoid personality. While his *I.Q. is borderline, his behavioural pattern* is *consistent with defect and deterioration*. Sterilization cannot be recommended on the presently given diagnosis, but, *if epilepsy or simple schizophrenia can be entertained*, then the operation subject to the consent of parent would be possible." In view of the above directive, this man has been passed for vasectomy, *subject to confirmation of a diagnosis* involving some type of psychosis, or to epilepsy with deterioration, and with his mother's consent. If upon further examination and observation it is decided to change the diagnosis in this case, it would be appreciated if I might be advised of this so that the patient's Eugenic file might be brought up-to-date (italics added, underline is in original).

With this case, there appears to be some creative maneuvering in terms of diagnosis. Why 'entertain' diagnoses unless there was an ulterior motive? The person is either sick or he is not. If he has a diagnosis that precludes sterilization, then why pursue the issue? There is no room for picking and choosing diagnoses when things are being run above board. It seems manipulative for the staff and Board members to "change the diagnosis" to suit their desire to sterilize this person, if that is in fact what occurred.

Changing Decisions

Something that has not happened previously in the Minutes is parents requesting that their children be sterilized, after the Board has deferred them[6]. Such requests might absolve the Eugenics Board of some responsibility for sterilizations.

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[6] A similar example appears in the February 9, 1966 minutes where a female patient was "passed clear for Salpingectomy, [but] her mother later requested that an Oophorectomy be performed.

This occurred at the June 16, 1961 meeting where a female was represented at the request of her parents

> who wish to have the child sexually sterilized. This case had been deferred by the Board when previously examined, but since the parents had submitted a written request that the case be re-considered and passed, and since the Director, Dr. R. R. MacLean, and Dr. L. J. le Vann gave it as their considered opinion that the intelligence rating of this child would not likely show an increase, the Board acceded to the parents' request.

These types of cases illustrate that the Board was not infallible. Its decisions were subject to change.

Re-presentations

There are several instances of people being re-presented to the Board because they got married. "Presented in 1948 and Re-presented because of marriage since original presentation to Board. There is no change in the original directions. Patient has signed consent forms and the husband is willing to do so" (November 29, 1962). Marriage is now a reason for sterilization, perhaps because of the increased chance of procreation. This occurred again at the January 31, 1963 and the October 9, 1963 meetings, where two other women were re-presented because they each were married since the original presentation.

Finally, another case was re-presented because it appears that the male patient somehow slipped through the cracks and escaped sterilization. Originally presented in 1936, it was decided he should be presented again before surgery occurred (March 14, 1967).

Amendment

As in the previous decades discussed, the Minutes of the 1960s also contain examples of discussions regarding amendments to the Act in an effort to incorporate more and varied cases (November 24, 1961; December 15, 1966).

Power: The Schizophrenic Board/Patients: Taking Back What Is Theirs

Power of the Board

There is a blurring of divisions between themes in the 1960s, since the discussion on pushing the limits of the Act in an earlier chapter is rife with examples of the Board's power and its willingness to use that power. The Board finds ample opportunity to flex its muscles in a somewhat different manner in the 1960s. As we will see in the next section, there are several examples of patients and/or their families exhibiting opposition to the Board's activities. These situations offer the Board opportunity to exert its power. Such power exertions appear in about 38% of the meeting Minutes. The following quote from the April 26, 1963 meeting serves as an example: "The Board discussed a request from [patient name] to have permission to 'have her Eugenics surgery undone so that she could have children of her own.' The Secretary to the Board was instructed to advise [the patient] that after giving her request careful consideration the Board was *unable to find any reason to reverse its original decision*" (italics added). It is likely that a surgeon would be unable to surgically 'undo' the operation, but the Board makes it sound like this is an administrative decision and not a surgical one.

Power of the Surgeons

As with the previous decades discussed, the Minutes of the 1960s illustrate the power of the surgeons to the Board. We see the same decision-making power given to the surgeons at the time of the surgery ("oophorectomy or hysterectomy at the discretion of the surgeon"; December 5, 1963). The '60s also witness discussions centering around the desirability of performing "Bilateral Salpingo-Oophorectomies or Hysterectomies in selected cases where surgery effecting amenorrhea is requested by the parents" (December 5, 1963; February 6, 1964). Of course, the surgeons play a key role in these discussions since they are the experts in this area. It is interesting that some of these procedures were carried out before the Board reached a decision on how such cases should be handled, before the information was in from the surgeons assigned to researching it.

Power of Superintendents

Superintendents too, continue to have and exert power. They appear to have more power than they did in the 1930s. In the 1930s it was the Board's job to liaise with the Attorney Generals' Department regarding advice in certain situations. Now, in the 1960s we find that individual superintendents are given the independence to consult with government as they see fit: "The presenting physician, Dr. Violet Myers, was directed by the Board to convey to the Medical Superintendent a request that he consult with the Attorney General's Department in respect to this case which is not a bona fide resident of the Province of Alberta" (May 6, 1964).

Dr. le Vann remains a key figure in the 1960s. He retains his powers of 'convincing' which we saw him perfect in the 1950s.

> The Board discussed this case with the Medical Superintendent, who had written the Secretary to the Board on September the 30th, 1963, stating that this girl's mother objected to having her daughter sexually sterilized. It was agreed that if the mother still refused to consent to the operation, the Medical Superintendent would be *justified in attempting to persuade* [mother's name] to remove her daughter from *the School.* The Medical Superintendent stated that he had an appointment with the mother for the following day, and would inform the Board of the results of this interview. (October 10, 1963) (italics added)

Le Vann continues to "play hardball" with troublesome parents. We see him extending his powers of persuasion via the mail at the February 9, 1966 meeting: "Dr. le Vann asked for the Board's comments on the following letter he had sent to the mother of [patient's name], and to which he had received no reply. "[mother's name]: The matter of recommendation of sterilization by the Eugenics Board with respect to [patient] was discussed with you, and since we have not heard anything to the contrary from you, we will shortly be carrying this surgery out. Unless I hear to the contrary within the next two weeks, I will assume this meets with your approval. Sincerely,". In the discussion following, it was decided that this form of letter was appropriate and that it was not thought necessary to send such letters by registered mail.

Several interesting points emerge from this discussion. The correspondence occurred through the mail. This raises questions of whether the mother ever received the letter. The second interesting point to be made here is the authoritarian way in which the Board operates. If the parent does not respond within a certain (rather short) time period, the operation **will proceed**. A third interesting point, and the point most relevant to the discussion of le Vann, is the fact that the letter had already been sent. He was in effect asking the Board for ex post facto permission. He either did not care what they thought, or else he was confident that they would support him. Either way, the Board had little choice but to approve his actions, since such action had already occurred. This one Superintendent made all the decisions in this case: he decided on the two week period of grace, he decided that the operation would proceed if the mother had not been heard from. He did this all on his own. It may simply be that le Vann is an enterprising and efficient Superintendent.

Le Vann, as we saw in the 1950s, tried to push for the presentation of younger and younger patients. The Board reined him in in the '50s. However, they appear to concede to his wishes in the 1960s. This is significant for the construction of this problem since the 1960s witness an increase in the number of younger people sterilized. In the 1930s 21% of all people presented were under the age of nineteen. In the 1950s, this number was 45%, and in the 1960s it was 61%. Le Vann's persistence may have had something to do with this. Here is the excerpt from the Minutes that illustrates this point:

> Business Discussion: A letter written to the Board by *Dr. L. J. le Vann*, under date of December 28th, 1962, was read and discussed by the Board. The letter requested a directive from the Board in respect to the age "*they would like to see children, both for interview as well as Eugenics operation*". After considerable discussion Dr. R. K. Thomson made the following motion: "It is recommended that *at the discretion of the Medical Superintendent of the Provincial Training School, Red Deer*, a trainee may be presented to the Eugenics Board for consideration of sterilization *any time after the age of twelve years*. Exceptions will be considered by the Eugenics Board upon application to the Board." Motion carried." (February 1, 1963)

Le Vann continued to push for younger presentation ages. In the 1950s the Board was hesitant, wanting to wait until the child reached puberty so that a judgement could be made regarding sexual tendencies. This kept le Vann quiet for awhile. But now a new policy has been implemented. This decision also empowers le Vann (or any subsequent Superintendent of the Training School) with the discretion to decide *which* twelve year olds should be presented for sterilization. The Board ultimately leaves itself in a position of power by adding the last clause, giving itself the power to make exceptions. Significantly the Board no longer cares about post-pubescent sexual tendencies; this was the original concern that gave them pause in the 1950s.

Patient Power

Patients had no power to speak of, aside from the quiet revolt of those patients who refused to consent to operations. There is one instance of patients exerting their power, although it is presented as the Board's portrayal of their 'business' activities as a way of helping patients.

> The Chairman also brought up the matter of certain *patients who might have wished to be presented* to the Eugenics Board, but who were discharged from Hospital "between meetings" and in some instances did not appear at the following Board meeting, although the ***Hospital authorities had made every effort to persuade them to return for presentation to the Board*** (June 28, 1962).

It seems fairly obvious that if patients 'wished' to be presented they would not have to be 'persuaded' to return for presentation. The example also illustrates patient agency in the form of not showing up at Board meetings.

Parent Power

Parent power in the 1960s was a mix of activities both in favour of and opposition to sterilization. Parents lead the way in terms of legal action against the Board (which is discussed in the next section), but they also led the way in asking for more intrusive surgeries. Parents seem to have initiated the drive for performing hysterectomies on certain women.

> ITEM OF DISCUSSION: The Chairman brought up the matter of parents requesting hysterectomies in certain instances where female patients were unable to attend to their personal needs at the time of menstruation. It was pointed out that whereas the Board had on occasion passed cases for oophorectomy, the operation involving hysterectomy had never been sanctioned. Dr. R. K. Thomson was delegated to obtain the professional opinion of a gynecologist in respect to the relative merits of these forms of surgery, and report his findings at the next meeting (June 21, 1963).

This topic continued to be a concern for the Board and they did perform hysterectomies (although they actually started doing this before this discussion came up) (October 9, 1963, December 5, 1963; February 6, 1964).

We saw earlier in this section that parents were influential in convincing the Board to change deferral decisions into decisions that resulted in sterilization. There were parents who wanted their children sterilized. But there were also parents who were opposed to sterilization of their children, and also parents who sought to take legal action against the Board for such sterilizations. Combined with the cases of patients who wanted their operations 'undone', we get a sense that there was definite opposition to the Board, more so than in the other decades examined.

Opposition and a Cautious Board

There are three cases of patients requesting their operations be 'undone' in the 1960s. Such requests were not as apparent in previous decades. We saw opposition and the odd request for a reversal in surgery, but in the 1960s, this type of concern is increasing. "The Board discussed a request from [patient] to have permission to "have her Eugenics surgery undone so that she could have children of her own" (April 26, 1963).

Another case similar to this one appears in the December 2, 1965 Minutes. Now, the Board seems to be getting concerned about the legality of the requests it is receiving:

> Correspondence regarding [patient's name] who is requesting that her eugenical surgery be undone, was read. Discussion. A letter to be forwarded to [patient] that this surgery was performed in her best interest at the direction of the Eugenics Board and according to law and permission to undo the surgery, if it were possible, can not be given by the Board. As well, it was suggested that this matter might be drawn to the attention of the Department of the Attorney General as to the legality for this if it were possible to undo the surgery.

The Attorney General does respond to this inquiry, and although the Board records attaching the memo to the Minutes, we do not have access to them (February 10, 1966). There is an additional example of a male patient who also inquires as to whether his operation can be undone (April 19, 1966).

One father actually started legal proceedings against the Board. However, it does not appear that anything much came out of this, likely because of the close association we see between the doctors and lawyers involved. Even when people tried to oppose, they were thwarted by the interconnections between the powerful actors involved. In this case, there was a close association between the two groups of experts involved in the situation.

> ...This correspondence had been referred to Dr. MacLean by the Honourable J. Donovan Ross, M. D., and the original letter was to the Minister of Health from [lawyers from an Edmonton law firm] and was written on behalf of the

> patient's father. The *letter implied that the father was upset because this surgery had been performed upon his son without the father's knowledge*. The Minister of Health asked Dr. MacLean to suggest a reply to [lawyer]. A copy of the suggested reply was read to the Board. The Board agreed that it covered the situation very well and thanked Dr. MacLean for his efforts. *Dr. R. K. Thomson told the meeting that* [lawyer] *was his patient and offered to discuss the situation with him*. It was agreed that this would be the best course of action, and the matter was left in abeyance (November 24, 1961).

We never find out what happens with this case, but because it does not enter the Minutes again, it might be safe to conclude that a solution was reached in Dr. Thomson's office. However, the Board seems to have taken this seriously and to have modified its actions somewhat. At the next meeting, (November 24, 1961) the Board "passes clear" a female patient but adds a condition we have not seen for awhile: "passed clear but with the recommendation that the parents sign consent forms". Perhaps they have learned from the legal case above to be more careful in their activities.

Summary and Conclusions

The activities of the Board in the 1960s were very similar to those of the 1950s. Power is a consistent theme throughout, in the 1930s, the 1950s and now the 1960s. The use of tests and the manipulation of diagnoses continued. Le Vann continues to play a key role in pushing for new policies and in 'persuading' people to see the error of their ways. We also see the continuing desire for expansion in the form of amending the Act that we saw in the 1930s and the 1950s. And the Board continues in its efficiency. The well-oiled machine analogy applies in the '60s as it did in the '50s. In fact, to illustrate this extreme efficiency, at the December 2, 1965 meeting "necessary forms were completed for two surgeries slated for December 4, 1965". The operations had been scheduled *before* the patients had been presented!

The Board in the 1960s, though acting in ways that are generally consistent with its actions in the 1950s, does portray a somewhat different image of itself during this time period. Outside influences enter the minutes more frequently and with a more threatening presence. The once rather arrogant, all-powerful Board seems to be a little less sure of itself. There are more discussions about the legality of performing the operations. There are more comments about consent and the recommendation of attaining parental consent before operating. Yet at the same time le Vann is still encouraged to 'persuade' parents to provide their consent. Even talk of expansion is cautious. Amendments to the Act are suggested throughout the Minutes in the 1960s until December 15, 1966, when "the matter of opening up The Sexual Sterilization Act was brought up. The Chairman stated that this matter had been raised two years ago and at that time the Minister of Health had not been prepared to do this." After this meeting there is no further talk of amending the Act at the meetings.

We see parents entering the picture more in the 1960s, both as initiators of more intrusive surgeries but also in the form of opposition and legal action. In trying to cater to the demands of these outside influences, or at the very least to be cognizant of them, the Board ends up acting in very contradictory ways. Its behaviour and decision-making in general lack the confidence it once had. We saw several cases in the discussion above where the patient was initially deferred but after coaxing from the parents, these people were sterilized. A deferral implies that the patient did not fall within the scope of the *Sterilization Act.* How can the Board in good conscience change its decision on something that "clear cut"? This bodes poorly for the image of the Board as an all-knowing arm of the government.

The 1960s generally saw more deferrals. This too, contributes to the loss of confidence that the Board exuded in previous decades. Something is wrong with a system that is so sloppy as to refer cases with insufficient evidence for sterilization or cases that so obviously fall outside the jurisdiction of the Board. Granted, as mentioned above, this problem likely had it roots in the institutions. But all were part of the same system.

The Board seemed to take a step back and relinquish some of its power to the individual Superintendents and surgeons. We saw in the '60s, as in the '50s, more cases where the final decision on type of surgery was left up to the discretion of the surgeon at the time of operation. We also saw a situation where individual Medical Superintendents were given the responsibility of duties formerly carried out by the Board itself. In other words, the medicalization of the "problem" has reached a new level. And this means more power for certain groups of professionals within the mental health system.

To summarize, the Board maintained power and control over its own activities and the activities of the institutions. However, we do see a somewhat more cautious Board emerging. Hence the schizophrenic nature of the minutes. At one meeting, the Board is comfortably flexing its muscles, informing a woman that her operation cannot be undone because she was sterilized for a reason and that reason still applies. At another meeting this same Board is turning to the Attorney General's Department for advice regarding legal issues. It seems that, in the 1960s, the Board's confidence has been shaken. Whereas in the 1930s the Board spoke freely of meeting with the Minister of Health to present ideas for amending the Act, in the 1960s, the Board is cautioned that there will be no re-opening of the Act for amending.

Why did this occur? What shook the foundation of the once all-mighty Eugenics Board? One theme that emerged from the minutes of the 1960s was outside involvement. Perhaps the activities of the Board were becoming more public. Perhaps, as more people were sterilized, so did more people think about having the operation undone. These are normal odds, the longer the Board was in operation, the more people it came in contact with and so the more likely opposition might grow. Also, it was the 1960s. People were more informed about their rights and the avenues available to them to exert those rights. Finally, Dr. J. M MacEachran, Chairman since the Board's inception, resigned June 30, 1965. After his resignation, the new Chairman, Dr. R. K. Thomson said that: "Dr. J. M. MacEachran would be greatly missed but that his shadow would remain with us" (December 2, 1965). The statement is prophetic. It could be argued that the exit of their long term leader shattered some of the confidence of the Board. Perhaps it was the loss of their leader that resulted in the "confused" behaviour of the Board throughout the remaining years of its operation.

It may also be that as the 1960s came to a close, political pressure was already developing for the repeal of the Act. The Board members may have sensed this and taken a more subdued role in an effort to keep a low profile until the storm passed.

At any rate, we do see a change in the Eugenics Board. What does the change in the Board and its activities mean for the social construction of the problem of feeblemindedness? Before looking at these questions in more detail, we first look at what was occurring with the sexual and family history construction at the institutional level for the three decades discussed above.

Chapter 8
"Institutional Constructions": Family History and Sexual History

The Institutional Data ('1 in 5 sample')

The Minutes of the Eugenics Board meetings provide a rather formalized conception of the social construction of the mental health system and the Eugenics Board. The Minutes document the ways in which the Eugenics Board treated the people it processed, how it justified its actions, and how it consolidated its power. The Board was an official government agency. The Board's decisions represented those of the Minister of Health and the government in general. The Board was essentially a formal bureaucracy created to deal with this 'problem'. As a result, the Board's activities and interpretation of those activities as documented in the Minutes have a formal, "government bureaucracy legitimacy" attached to them. To tap into a more descriptive component to the construction, I examined the '1 in 5' data source. This is a database that includes the file information on one out of every five individuals who were presented to the Alberta Eugenics Board throughout its operation (1929-1972). There are 861 cases in this '1 in 5 sample'. Specifically four "variables" are analyzed: diagnosis, sexual history, family history, and reasons for sterilization. These variables are written statements that have been entered verbatim into the database.

These 'write-ups' were produced by the institutions presenting individuals to the Board. The information was taken from the "Presentation Summaries" which were provided to the Board members so that they could have a brief history of the individuals appearing before them at the meetings. My goal with this source of data is to also discern the types of people who were being presented to the Board, and to look for patterns that may exist in the ways in which these peoples' histories were constructed by the institutional staff prior to presentation before the Board.

These are formal constructions since they do impact on the Board's decision making; they are essentially the institutional story of and justification for presenting the patient to the Board. In their creation and effect, they are 'formal'. But they are constructions that are formulated by different people, with different interpretations of who should be presented. In addition, these people are representing different institutions. In analyzing these variables it is interesting to see whether the various contributors produce the same constructions, the same descriptions of people needing to appear before the Board. Likely, there will be similarities since these were social workers and psychologists who were trained to look for similar characteristics or tendencies. In addition, it was likely that the Superintendent in each institution set the tone for what was to be written by the workers.

Presentations to the Eugenics Board were made on the recommendation of two psychiatrists. We can assume, based on the nature of professional relations within institutions (hierarchical relationship between Superintendents and psychiatrists and social workers), that once this decision was made, the staff writing up the presentation summaries had a formula to follow. By analyzing the various constructions, we should be able to provide another perspective on the way in which the problem of feeblemindedness was constructed, this time at the institutional level. Although the Board had the final say on who was sterilized, the institutions and their representatives played a crucial role in determining who reached the Board level. As 'feeder institutions', the Board depended on these people to provide them with their 'clientele'. In terms of constructing the problem, the institutions were crucial since it was they who sought out "problem" clients and passed them on to the Board for final approval.

These institutional data should also illustrate if the constructions at this level changed as time went on. Was there something about the sexual history and/or family history of these patients that was deemed important in the 1930s that was different from the 1960s? Did the reasons for sterilization change over time? Having analyzed the Minutes of the Board meetings during these time periods and having seen an increase in efficiency and confidence of the Board, we might also see changes in the reasons for sterilization assigned to each case.

What follows is an account of how the problem of feeblemindedness and mental illness was socially constructed, based on an analysis of the institutional information provided on the family and sexual histories, diagnosis, and reason for sterilization for people presented to the Eugenics Board. Family history and sexual history are analyzed in this section. They are grouped together because both are integral to the underlying philosophy of the eugenics movement that genetic conditions were passed on through family lines. Therefore family history of genetic conditions, and sexual/reproductive behaviours are key components in the construction process. Family history is discussed first.

Family History

The core premise of the eugenics movement was that "feeblemindedness" and other psychiatric disorders had a genetic basis. Hence, to improve the race, sterilization of those so afflicted was necessary, so that they could not pass on their disabilities to their children. Recognizing the importance of demonstrating how such disabilities were being passed from one generation to the next, the Eugenics Board included a section called "Family History" on the presentation summary sheets it used when considering individual cases. When available, information about a family history of feeblemindedness or psychiatric disorders was recorded in this section.

Something about the patient's family history was written in the "family history" section in all but sixteen of the 861 presentation summary sheets in the '1 in 5' files. A careful reading of this material allowed us to create an 11 category coding scheme (see Box 3 below). The first six categories were used to classify written observations that, at least to some extent, indicated that some other family member had or continued to suffer from some form of mental disability. The remaining five categories were used to classify other information recorded in the "family history" section that either explicitly stated that there was no family history of mental disability or, by its omission, implied that there was no such history.

Figure 1 displays the distribution of "family history" comments for the 861 cases in the '1 in 5' sample. Most noteworthy is the fact that, for 326 cases (38% of the total), the Eugenics Board was explicitly told by the institutions/individuals presenting the case that there was *no* history of mental illness in the family. If we include the cases where the patient denied such a history and where no information was available, we account for 47% of all cases. And if we add in the comments about alcohol/ promiscuity/ character defects and the comments about health and family problems, we now include almost two-thirds (62%) of all the "family history" comments in the '1 in 5' sample. In only a minority of cases (38% in total) was the

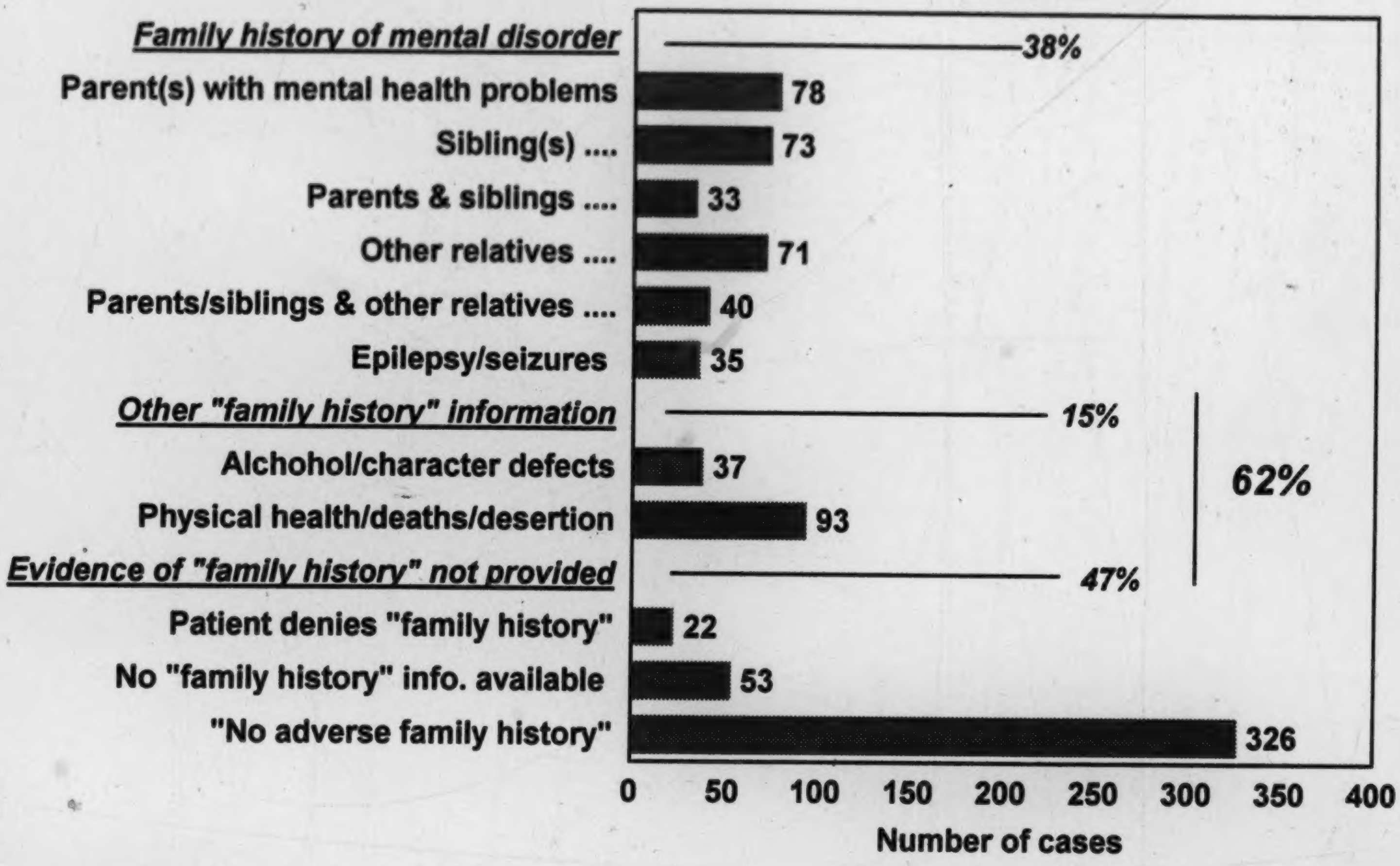
Box 3: Categories of "Family History" of Feeble-mindedness/Disorder

Evidence of "Family History" Provided
(1) Parent(s) with mental health problems
(2) Sibling(s)…
(3) Parents & siblings…
(4) Other relatives…
(5) Parents/siblings & other relatives…
(6) Epilepsy/seizures in family history

Other "Family History" Information Provided
(7) Comments about alcoholism/promiscuity/ character defects
(8) Comments about physical health/deaths in the family/desertion/ poverty

Evidence of "Family History" Not Provided
(9) Patient denies "family history" of mental health problems
(10) No "family history" information available/nothing recorded
(11) Negative/adverse heredity not elicited/ no adverse family history

Figure 1: "Family History" of Feeble-Mindedness or Psychiatric Disorder ('1 in 5' sample) *



* Source: '1 in 5' files; grouped comments about "family history" as recorded on "presentation summary" sheets (N = 861).

Board presented with evidence of some family history of feeblemindedness/ psychiatric disorder/epilepsy. As we see below, some of this evidence was not particularly convincing. Even so, the Eugenics Board passed virtually all the cases that were presented to it and typically did so with the explanation that sterilization would ensure that the mental disability would not be passed on to future generations.

Females and Males: the 1930s

The primary purpose of this family history information was to illustrate that these people were, in fact, a threat to future generations, that their family history included something detrimental to the human race that could be passed on genetically. This section analyzes what was written about patient family histories during the 1930s, with particular attention paid to gender differences. While they are not mentioned often, the fact that such issues as ethnicity, class, and promiscuity appear at all is worth documenting, since the family history section was meant to document genetic disorder. The themes discussed are those which should technically not appear in the family history section of the presentation summary documents, yet do.

This discussion also includes a look at the 'reason' for sterilization assigned by the Board after reading the presentation summary and seeing the patient. In essence this is the decision of the Board after looking at all the evidence. By tying together the family history constructions with the final decision of the Board, we are able to more clearly see how it was that the institutions and the Board worked together in constructing this social problem. After examining the family history variable for males and females in the 1930s, we analyze and compare the two. Then we look at if and/or how the social construction of family history changed over time.

The Relationship between "Constructor" and "Constructee"

One gets a very distinct impression from reading the many male and female family histories that the writer was having difficulties getting information from the patient or some other relative. We find many words and phrases that imply that what is being written may be hearsay. In one case, the patient's sister, Ethel, "is regarded by the patient's husband and others as being mentally abnormal" (1447[1]). It is interesting that the writer recorded it regardless. Essentially in many of these cases, mental health institutions were collecting information from people that they would have to admit were too incompetent to be capable parents.

These were 'mentally defective', 'mentally ill' people. Yet they were interviewing these people asking them about their family histories! One patient's mother, according to the patient, was "sick due to too much dancing and parties" (647). The very nature of this interview process is questionable.[2] First, as we saw above in Figure 1, we have information that is for most people incomplete and/or lacking. Secondly, this information is based on the patients' own personal, possibly 'defective' testimony. The stories presented in this analysis have been put through two filters already: the patient provided information he or she thought was important and then the person writing the family history interpreted (and judged as true or not, or even worthy of recording) what was said. Now this information is interpreted and re-constructed in this analysis. What is particularly frightening about this is that the doubly constructed, doubtful (mental state of patient; filtering of writer) construction was used by the Board to influence a very important decision-making process.

What appears in these constructions is the subjective, unreliable nature of the construction process. An early female case in the '1 in 5 sample' reads in part as follows: "No psychopathic history *admitted* on either maternal or paternal side…" (175) In another case "one sibling in the family is *reported* to be epileptic" (882). One patient's father is "*said to be* of low average intelligence". For this same case, the mother is "*said to be* nervous, irritable, and unstable" (906). Who is saying this? The town doctor? The town gossip? A popular phrase used in the family histories follows a format similar to the following: "All insane, epileptic, and defective heredity *denied*" (1001). One gets an impression about the information gathering process with the following comment: "No history *could be secured* from the patient" (1561).

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[1] The numbers placed in parenthesis refer to the Eugenics Board number of the cases discussed. These numbers have been changed from their original format in order to protect the anonymity of patients.

[2] Note: there are instances where we get the impression that other official reports supplement patient accounts – for example, police reports.

Vagueness of Descriptions and Diagnoses

Not only do the institutional staff writing the family histories seem to doubt the stories being told to them by their patients, they also appear insecure and unsure of what they are writing about these people. One patient's father is "possibly borderline" (175). For another, her mother is "probably subnormal" (171). One patient's husband is "basically a moron" (233). Another patient's mother is "not very healthy and *probably* subnormal". Unfortunately her father, too, is "*probably somewhat below normal* mentally" (403).

The staff seems to reach many of their conclusions based on appearance -- the way people look, in their opinion. A patient's brothers "aged 25, 18, and 16 *appear* mental defectives and *are said* never to have passed grade 1" (354). One wonders if the entire family was paraded in front of the staff member and given an "armchair" diagnosis. Another patient, whose father is dead, has a mother who "is an *old lady* who is *probably senile*" (882). One patient has a maternal grandmother, who "at the age of 87, is 'a little off'" (1471). This type of conjecture is used not only to describe the present situation of patients and their families, but also to infer about past behaviours. For example one female has an epileptic father and it is "doubtful if he was always mentally sound" (942).

A 1937 case provides an example of the type of vagueness described above: "…one brother suffered from fits when a young child. The family history in this case is *quite suggestive*. A brother and a sister, who were seen at the Clinic *would not appear as being high grade*" (960). What exactly does 'quite suggestive' mean? In one patient's write-up we find that "one brother had *some birth injury* and was blind and could not talk…" (1579). Was the blindness and inability to talk a result of "some birth injury" or was it a genetic disorder that caused this?

This uncertainty or inaccuracy becomes most pronounced when we come across a case where in this patient's family there are "three children of borderline intelligence, and one *definitely* moron." Another patient has a mother who is "*definitely* defective" (629). The choice of word 'definite' implies that perhaps some of the other 'diagnoses' were themselves questionable.

In both male and female family histories there is the hint of recognition on the part of staff members that some of these ailments might be curable. But if they had evidence that some conditions were curable, why did they continue to construct these conditions as genetic diseases that needed to be controlled through sterilization? In the case of one patient, the sister had a mental breakdown but was "recovered" (793). In another, a mother had been a patient in the institution but "following her discharge there was no recurrence of mental symptoms" (805). What is interesting with the cases is that they are asked specifically if there is "insane, epileptic, alcoholic and defective heredity" in the family (463). Starting in 1938 we see that they are asking patients specifically about a "family history of heart disease, nervous disorder or cancer", at least at some of the institutions (1429). It appears that in the late thirties the construction of family history has changed somewhat in that now included in the list of heritable diseases worth eliminating from the race are heart disease and cancer. Rheumatism and asthma, as well as diabetes, enter the family history summaries throughout the thirties as well. It appears that the staff members producing these summaries were constructing the problem of eugenics to include all sorts of ailments, heritable or not. Was the aim to just get rid of "sick" people, no matter what the sickness and regardless of whether or not it was a genetic disorder? It appears that this is the case.

Character Judgements

The family history section of the presentation summary, originally intended to document instances of hereditary diseases in a person's family history that made him/her a candidate for sterilization, quickly became, for both females and males in the 1930s, an opportunity to document any hint of family or behavioural dysfunction. It was a place where sexual behaviour, alcoholism, poor performance in school, employment status, distant relatives' escapades, and many other things could be recorded. In addition, the authors of these family histories also included their own judgements on the situations and people involved.

The female case 171 has an extensive family history. Some highlights read as follows: "Husband was *lazy and shiftless, his farming sporadic and careless*. They lived in a *shack which was dirty and in poor repair*..." The family history is riddled with such negative judgements. In this same case we find that the husband's side of the family is "definitely low grade", and that they have "*poor personalities*. Patient side also low-grade, but with *better personalities*."

One patient's mother is "said to have had a very unstable personality. Worried and cried frequently…" (457). Another patient's father was "none too bright" (629). In this same family, "the children were dirty, ragged and the house was in a deplorable condition." These descriptions seem to be infused with rather subjective and judgmental adjectives. They indicate an 'us' versus 'them', 'us' as normal, 'they' as not normal, dichotomy. One patient's mother's "judgement appears impaired and her emotional reactions often inappropriate" (1200). Still another mother is worthy of mention in the family history section because she is "high strung, irritable, and interfering" (1242). A father is described as a "ne'er-do-well" (707) and another father is a "heavy drinker and a shiftless type" (1025). Thus, the genetic construction of family history has little to do with hereditary characteristics. Rather, the concern is more with social characteristics, of which we will see more.

Siblings do not escape the assignment of value judgments and labels. One sister is "rather reserved and nervous" (1073). In another case the patient's "brother and sister are both peculiar and erratic in actions, while introverted, and would appear to be on the verge of psychosis." Another patient's older sister is "said to be unstable" (1110) which appears to be seen as evidence that the younger sister will likely also inherit this dangerous family trait and pass it on if not sterilized. Another patient's sister is "said to be shy and hypersensitive. A second sister is said to be nervous and suffering from insomnia. A third sister is said to be noisy, excitable and talkative." (1200) It seems, in this case, one cannot win. You are recorded in the family history if you are shy but you also will merit mention if you are outgoing!

Thus, we see that staff members have moved away from the original intention of the family history write-up which was to document diseases transmittable through heredity. We also see pronounced value judgements. The criteria are set by the middle class helping professionals who document the family history. Because of their 'professional' status, their judgments are taken to be scientific, medical, and therefore informed.

Poverty, Class and Occupation

Economic situation sometimes enters the family histories. Mention is made of economic status or occupation in about six percent of the male and female family histories in the 1930s (n=240). The words used to describe the financial states of these families seem to point to a rather distinct class difference between 'constructor' and 'constructee'. We saw this above with the family that lived in a shack that was dirty and in poor repair. We also see it in one case where "economically, [patient's father] was never very successful" (277). The authors also found it significant to comment on the income of the family. For instance several families are "on relief" (882). "Her father has not had steady work for years and been on relief for the past 4 years"(906).

The institutional staff members writing the family histories also tended to mention the occupations of the parents, usually the father. This too, looks like a concern not with hereditary traits, but rather with economic or class-related factors. For example, we find out that one patient's father is "a labourer and has had difficulty in making an economic adjustment" (641). One of the "ne'er-do-wells" mentioned above is "a miner, has been on relief much of the time the last few years…" (707). One father, who deserted the family eleven years *before* the write-up is completed re-enters the family history: "He is said to be on relief in Saskatchewan now" (1321). The relevance to this patient's family history is questionable. Again, it is unclear what such statements have to do with mental afflictions that are thought to be passed on from one generation to the next. However, such statements very clearly enter into the construction of this social problem of feeblemindedness.

"Proper" Habits and Behaviour for Women

Also frequently mentioned in the family histories is the fact that some of these people behaved in ways that seemed to the writers to be outside the realm of appropriate or proper behaviour. This seemed to be a particular concern for the female relatives of the patients. In eight percent of the female family histories (n=125), but in only one of 115 male cases (0.8%) was mention made of promiscuous behaviour on the part of the patient or a family member. One patient's mother was "married three times and weighs over 250 lbs" (373).

There are many comments that pertain to women being hysterical, experiencing depression after childbirth, being nervous and worrisome, or otherwise weak. One such female, a mother of a patient "had a short mental breakdown, with depression at the menopause" (349). In another family history we read that both of the patient's parents are living and well, "except that the mother is passing through the change of life." (391) This is enough to warrant mention under family history, which also implies a psychological or psychiatric heritable trait. Another mother "became mentally ill following child birth" (707). Thus, "female problems" and female sexuality are seen to be relevant to family history.

Ethnicity

Comments about the ethnicity or race of patients and their families also enter the family history write-ups in about six percent of cases. This contributes to the construction of the problem in that one of the main factors influencing the eugenics movement was the concern with race and ethnicity. For one patient the family history consists of simply "an old father, and a senile, *half-breed* mother who died of tuberculosis." In another case, the staff member writing the family history referred to the mother of a patient as "a Cree quarter-breed" (1091). Another patient had siblings, "several defective and the youngest one *'colored'*" (942). Obviously race is a concern for these writers.

Mention is sometimes made of family in or from the "Old Country" which implies that the patient and/or his family are immigrants[3]. These staff members thought it worthwhile to mention asylums in Germany, hospitals in Russia, and contact with relatives in the Old Country. They were making the point that immigrants and "half-breeds" were in some way "defective".

Social Dysfunctions

As illustrated in Figure 1 above, 62% of the family histories were based on information that had more to do with family behavioural or social dysfunction as opposed to hereditary conditions. Alcoholism and character defects were part of this category. For female patients and their female relatives, promiscuity was a common theme. One patient's "own family history includes six children, each with a different father" (641). A maternal grandmother "had four illegitimate children, of whom the patient's mother is one…"(912). Another patient's mother "was running about with various men" (629). And yet another has a mother who "has lived as a common-law wife with several men" (1321). One woman is a "patient with a promiscuous mother whose present whereabouts are unknown" (252). The reason for sterilization for this case is "family history". Apparently promiscuity is hereditary.

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[3] The following are some examples of these type of comments: 894 – "one sister is at present in a mental hospital in the Old Country"; 989 – "two brothers alive and well in the Old Country"; 1019 – "the patient has not heard from home for 17 years…"; 1453 – "…one brother is said to be in a hospital

What do write-ups like this tell us about the social construction of the patients' family history? It seems that the writers were setting out to 'punish' children for their parents' indiscretions. The patient's own behaviour is, at least in this case, irrelevant, since her sexual history reads as follows: "no undue sex interest noticeable". But even in talking about behaviour we are missing the main point: the family history variable was intended to record instances of *hereditary* diseases or conditions. A mother's sexual behaviour is *not* worthy of mention under the heading of family history and the fact that it is, is significant in terms of the social construction of this problem.

Alcoholism is another character defect that often enters the family history write-ups. It is primarily the fathers who are alcoholic. Alcoholism or the 'heavy' use of alcohol appears in six percent of the male and female cases. The first mention of alcoholism in the family occurs with [case 361]: "Father drank heavily, was cruel to the family and has been separated from them for five years". Another family history starts off with the following: "Father, 59, healthy, non-alcoholic…"(641). What is this person saying about men at the time, families at the time, or the social constructions of feeblemindedness at the time? For some reason it is worthwhile to mention the *absence* of alcoholism in this family. We are left wondering if the author is perhaps shocked at the discovery. Maybe from her perspective most families 'of this type' are characterized by character defects. Maybe in her experience with writing the family histories most fathers in fact alcoholic.

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somewhere in Russia"; 1549 – "Mother died in 1917 at 45 years of age in a mental institution in Germany".

Crime

There are only a few instances of criminal behaviour in the family history write-ups. But again, infrequent as they may be, the fact that they are mentioned at all is what is significant. "One half brother of the patient served 7 years for manslaughter; is now on relief" (1091). Another patient's father "shot and killed himself after having killed his child in a fit of anger" (1152). In this same family, "two younger brothers he says are criminal and bootleggers. Another younger brother has been in jail for theft". Another patient's mother was "killed at 35 with an axe at the hand of her nephew 20 years ago" (689).

Orphaned Patients

The death or desertion of fathers and the orphan status of patients and their siblings is also a 'theme' worth mentioning. In particular, deaths of fathers as a result of the War, or because of accidents, illness, or suicide seem to be a significant theme in these family histories[4]. It appears in seven percent of the family histories of males and females.

'Good' or 'Blank' Histories

As we saw in Figure 1 above, the vast majority of cases had nothing significantly "genetically wrong" with them, at least as recorded in the family history section of the presentation summary. Within the '1 in 5 sample' for the 1930s, a large proportion of female and male family histories were either 'good' ("Patient is happily married. Children are normal.) or else they were left blank. In fact, in 43% of cases in this decade the family history is considered normal or there is no information provided on the patient's family history. There are noticeably more male family histories which are "negative", which means they are absent of any unfavorable conditions.

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[4] Some examples are as follows: "Father committed suicide at 63 years…" (500); "Father died at the age of 56 with influenza…" (568); "Father dead, mother remarried" (575); "Father died old age…" (647); "Father died at 44, after 8 years of diabetes…"(671); "Father died at 45 of wounds received in the Great War" (799).

Gender Differences in Family History

As we saw above the social construction of family history was generally similar for the women and men. But there are also some gender differences, which are discussed in this section.

No mention of Promiscuity

One of the most obvious differences is the lack of any significant discussion of promiscuity in the male write-ups. For women, there is a definite overlap between family history and sexual history. Particularly, the sexual history of mothers was constructed as something that could be passed on to daughters. The implication was that if a patient had a promiscuous mother, the daughter was likely to become promiscuous as well. Several cases exist where a female was recorded as not sexually active, but the sexually promiscuous mother warranted "promiscuity" as a reason for sterilization. Another issue then becomes the definition of promiscuity. Women who remarried or entered several common-law relationships after being deserted by their husbands were considered promiscuous, as were girls who had one or two heterosexual experiences. Also, girls who masturbated but never had a sexual experience with another person were documented as being promiscuous.

We must also consider *who* it was that was doing the constructing. Likely for female middle class moral entrepreneurs, a woman who divorced her husband or who entered into a common-law union was acting inappropriately and deserved the label promiscuous. It was probably considered inevitable that such a woman's daughters would follow in her footsteps, and so, should be sterilized to stop this pattern/cycle. The males in the sample did not appear to have to worry about promiscuous behaviour, at least not in terms of the recorded family history. Promiscuous parents, or rather, promiscuous mothers were not a concern for the staff members who were writing the family histories of the males.

What are the implications of these findings and the differences between the male and female family histories? The findings seem to reflect what was being discussed in the public domain regarding eugenics. Immigrants, the poor, women, criminals, and deviants were targeted by the movement. We see in the family histories that these issues played an important role in the institutional construction of this social problem. The institutions and the Board were going above and beyond what the *Sexual Sterilization Act* stipulated was the "legal" reason for sterilization. Thus, there was a very real medicalization of deviance going on in Alberta institutions in the 1930s. Social class issues and issues relating to deviance were constructed in such a way as to make people think that sterilization was the answer to these social problems.

The family history information, which was originally intended to document instances of hereditary diseases in a person's family history, quickly becomes an opportunity to document any hint of family or behavioural dysfunction or a straying from the norms as defined by middle class society. In other words, the family history section of the presentation summary becomes a place where sexual misbehaviour, alcoholism, poor performance in school, unemployment status, distant relatives' escapades and a great deal else is recorded. In addition to documenting these social behaviours (not only hereditary disorders), the authors of these histories also felt free to include their own judgements on the situations and people involved.

How does this influence the social construction of the problem? First, information on genetic disorders was lacking in the majority of cases. Second, we see that staff members who are in a position of power, the position to write these family histories, have moved away from the original intention of the family history write-up, which was to document diseases transmittable through heredity. Third, because of the power differential, we see in the family histories value judgements according to what seem to be middle class criteria for normalcy. Finally, there are differences in the constructions of family history for the genders, differences that may have contributed to the differences in chances of being sterilized at the hands of the Eugenics Board.

The 1950s

We saw in Chapter Seven how the Minutes of the meetings for the Eugenics Board changed from the 1930s. The differences indicated less of a concern with patient welfare and consent, and a greater push toward efficiency in processing patients. We also saw that some of the same concerns emerged in the 1930s and in the 1950s. There appears to be some consistency in the construction of the mental health system and the Board's construction of its activities. What about at the institutional level? Do the family history constructions follow the same format and focus on the same 'themes' as they did in the 1930s? Have the constructions changed in the 1950s?

The same general themes appear in the family histories in the 1950s as appeared in the 1930s. The wording used implies a mistrust of the patients, there is vagueness in the diagnoses and descriptions, character judgments are made, and social class position enters the picture in the same manner as before. As well, proper/improper habits are frequently recorded, as are behavioural dysfunctions and ethnicity. In this sense the constructions do not change very much.

Orphans/Wards

There are some subtle differences though, in the ways in which the emphasis on these themes occurs. In both decades, there are cases presented where the parents are dead and the children (including patient) are orphaned. The percentage of cases exhibiting this theme are the same as earlier – about six percent of male and female cases are characterized by the loss of a parent and becoming an orphan. In the 1950s, being orphaned seems to mean becoming a Ward or else being admitted to an institution. "[Mother and father are both dead.] Father had deserted family in 1921…[Sibling]…said to have been a patient in the mental hospital at Weyburn Saskatchewan. Little is known of the siblings as the children were scattered among neighbors and institutions when the father deserted following the mother's death" (2824: 1950). There is a suggestion that some cases involve patients whose parents are dead and whose siblings have already been admitted to an institution. Part of the reason for the emergence of this theme may be the fact that during the 1950s and 1960s there was an increase in the presentation of younger patients. Since more, younger patients were presented, it is realistic to expect that more of these patients might also experience problems with parents, in this case, the absence of parents.

The question that begs to be asked is how many of these patients were presented (and sterilized) because they had no family to take care of them or defend them? If the institutions were concerned about broken families and family discord one rationale for sterilization may have been to stop the creation of more dysfunctional families by sterilizing members of broken families. Case 10141, eventually deferred, included the following family history: "Both parents are deceased." This person, it is stated in the case file, is not psychotic, has a behaviour problem and is of borderline intelligence. Essentially, she is an orphaned child, with no parents to discipline or supervise her, who is not a mental defective. She is 'normal'. Yet, she was presented for sterilization. One wonders if being an orphan was reason enough to be presented during the 1950s.

More Mention of Siblings

By the 1950s, the percentage of cases where siblings were presented (or had been presented already) increased to 11% for both sexes. In the 1930s such a history was evident in six percent of male cases and only two percent of female cases. As this next case illustrates, the 1950s witness an emphasis on siblings in both the male and female family histories. "Two [siblings] died previous to patient's admittance to P.T.S. One sister is a mental defective. Father deserted the family....since that time the children became wards of the Government" (2809). Siblings who are admitted to institutions, siblings who are Wards, siblings who are incapable of caring for the patient - whatever their circumstance, we see much more talk of siblings in the 1950s family histories.

In one case we find out that "three siblings died in infancy as a result of convulsions" (2869). In another case "one sister had illegitimate child" (2939). In yet another case: "...patient states her sister... is an epileptic and from outside information it appears that both sisters are abnormal and are unable to speak properly" (3174). As in the 1930s, the family histories in the 1950s are constructed to include information, dubious or not, on patients' siblings' possible mental illness, promiscuous behaviour and abnormalities.

It seems though, that unlike the 1930s, the emphasis is on siblings who have been committed to an institution. This might be because the mental health system has had two decades to develop. In other words, there may be more people with a history of institutionalization because the system has been operating for awhile. As well, there is more detailed documentation of siblings' educational attainment. This emphasis likely is a result of the increasing importance of education in society during the 1950s. One patient's sister "is 17 and in grade 9 but her slowness may be due to poor vision" (3634). Another patient has eight siblings, "three of which reached only grade five in school" (3014). "[Mother] has had 10 children, one died at 2 years of age, the result of an accident, another son was a trainee at the PTS for a number of years, and the mental and physical condition of the other is not stated, although most of them did not advance beyond junior high school" (3719).

We also see two instances where the sterilization of a sibling or other family member is mentioned. The fact that a patient's siblings were 'worthy' of sterilization must be proof of genetic problems in the family line. This adds to the strength of argument that the patient too should be sterilized.

Illegitimacy

Promiscuity is another theme that was evident in the 1930s, but that has taken a slightly different form in the 1950s. In the 1930s many females were labeled promiscuous. Their mothers' sexual behaviour also became fodder for the family history write-ups. In fact, several females were presented for sterilization on the basis of their 'promiscuous' behaviour. Interestingly, the word 'promiscuous' appears only once in the entire sample of female family history write-ups for the 1950s. Instead of an obsession with female promiscuity (patient's and any female relatives'), the family history writers of the 1950s focus on illegitimacy. Unlike the 1930s where males escaped the promiscuity focus, they too receive attention regarding illegitimacy. This focus, illustrated below with some case examples, fits in well with the overall emphasis of the 1950s which seems to be a focus on children, siblings, and their status as wards or mental defectives. This focus corresponds to the increasing activity on the part of the Provincial Training School. This school became most active during the 1950s and 1960s. Its clientele were primarily young children and adolescents.

This emphasis on promiscuity, in the form of illegitimate children, enters the picture very early on in the 1950s. In 1950 this case appears: "[Patient name] is an illegitimate child, and [name] is only the name of her adoptive father. Of her mother…it is recorded – 'is a moron'" (2812). In the following example the patient's illegitimate status precedes any of the other "family problems" mentioned in the family history. "[Patient name] is the illegitimate child of a …who died giving birth to [patient name]…[Father] is reported to be bad tempered and a heavy drinker."

(3249). There are seven cases (7%; n=96) of illegitimacy mentioned in the female cases and two such cases for males (2%; n=98).

Finally, from the construction of the following family history one cannot help but get the impression that the writer is arguing that illegitimacy is hereditary. "…Mother…first came to the attention of the Calgary Guidance Clinic in 1937, at the age of 17. She was *referred because of illegitimate pregnancy* and her desire to marry the putative father…*Mother herself was an illegitimate child*. She was refused a marriage license on the grounds of being mentally defective. . Intelligence Classification High Grade Imbecile. It was also noted that she had not attended special Class in school. Her Mother and Grandmother were both said to be defectives…" (3034).

The wording in the second sentence provides us with an admission of sorts. The mother was 'referred' to the Guidance Clinic because of her illegitimate pregnancy. Not because of her mental defectiveness or her mental illness, but because of her promiscuous *behaviour* which resulted in a pregnancy, and her desire to marry.

Abuse/Incest

Another theme that seems to receive more emphasis in the 1950s is the mention of abuse and incest in the family histories. This may be the result of increasing awareness among social workers and others of the problem. The first such case appears in 1950: "…It is said by the mother, in an interview with her at the Guidance Clinic, that the father was a very heavy drinker and the family were terrified of him" (2839). In one case history from 1955 we read that: "the father flew into rages and beat the children and wife with anything at hand" (3244).

Incest also enters the picture. It did so in the 1930s as well, but it is worth mentioning in the 1950s data because the attitude taken toward female victims of incest does not seem to have changed on the part of the constructors of the family histories. In 1954 we read about the following family history: "When Rose's mother was 14 years of age, she had an incestuous relationship with her father. Rose is the progeny of that union; therefore, Rose's father is also her grandfather. He was sentenced to a term in the Penitentiary for this offence" (3094). In this case, it is the patient's mother who was the victim of incest. The fact that it is mentioned shows that it is important to the case history. About five percent of the family histories exhibit physical or sexual abuse.

Physical Ailments

There is a noticeable difference in the male family history write-ups in the 1950s. There is more frequent mention of general physical ailments, more than with the female family histories, and also more than there were in the 1930s for both sexes. In four percent of female cases and in eight percent of male cases, mention is made of physical ailments that are not genetically-based. In one case: "Father has chronic bronchitis and has never been robust. Mother had flu and was troubled with heavy cough during the last month of pregnancy. She also had dyspepsia during entire pregnancy period. Paternal aunt died of T.B. Cousin is somewhat like patient. No other history of note" (2879). One patient had "no adverse heredity except that, on the maternal side, six aunts who had exophthalmic goitre" (3159). Physical, non-hereditary ailments are being recorded with more frequency, for males. It may be that there was a concern with sickly people and their ability to work and provide for families. Since poverty and class position continue to enter into the family histories, it would not seem that far-fetched to think that, consciously or not, there may have been a concern on the part of staff with patient's ability to work.

Class Concerns

Interestingly, there is more frequent mention of poverty, occupation and social class issues in the 1950s in the write-ups for both sexes. Class or occupation is mentioned in 10% of female cases and 11% of male cases. Part of the drive for a eugenics program concerned the 'tax burden' that the so-called feebleminded population had on society. For this reason, a concern with poverty and unemployment is not surprising. What is surprising is that this information enters the section of the presentation summary where hereditary disorder is to be recorded.

The 1960s

It is remarkable that in the thirty years that the mental institutions and the Board have been operating there is so little change in the format, style and content of the male and female family history write-ups. As with the write-ups for the 1950s, any one of these family histories could be placed in the 1930s group and it would be difficult to notice any difference. The themes too, are the same. Alcoholism, abuse, incest (females as victims, males as perpetrators), death, divorce, remarriage, illegitimacy, common-law unions, ethnicity, extended and immediate family members who are institutionalized or otherwise "abnormal" in demeanour, and parents who cannot care for their children are all mentioned for both males and females. The same wording is used in both decades: people are "probably subnormal or defective", things are "reported" to be a certain way, other information is "elicited". In other words, the hearsay quality, vagueness, and general mistrust of the patients' and others' reports are still evident. Also, the focus on economic situation and occupations is as pronounced as it ever was. For females, promiscuity is discussed but not for males. For males, discussion of criminal sexual incidents on the part of patients and male relatives is more frequent. For both sexes, there is also considerable mention of other, non-genetic and non-mental conditions: asthma, cancer, goitre, muscular dystrophy, leukemia, cerebral palsy, pneumonia. This is different from the 1930s, but similar to the 1950s. In other words, despite a few minor changes in content, the family histories of the 1960s remain similar to those of the 1930s and 1950s. Despite changes in scientific theory, medical evidence and other cultural changes around them, the institutional staff is still following the template for family history write-ups established thirty or forty years earlier.

Conclusions

I started this chapter with two goals in mind. The first was to discern any differences between the sexes in terms of family history construction from the 1930s to the 1960s. The second goal was to ascertain whether there was a change in the construction of feeblemindedness as evident in the family history information in the presentation summaries. To address the first issue: we can conclude that generally the differences are not significant. We can make some general observations regarding such differences. For example, there are more instances of incest for females (and none for males) in the 1950s but there is 'abuse' in the families of both genders. Also, though for females there is more emphasis on illegitimate children that the patient has had, for males the theme of illegitimacy still is evident. It may be other family members' illegitimate children, or the legitimate status of the patient himself that is the issue. This may be a result of the increase in the number of younger patients presented during the 1950s and 1960s. But the fact is that illegitimacy, whatever the form, is still mentioned for both groups. So, while a difference in form occurs, the content or the issue is the same. This theme remains constant, regardless of the specific label applied, throughout the decades in question.

Perhaps one of the most apparent differences in the write-ups is the mention of other physical ailments in the male write-ups. We saw above that flu, bronchitis, asthma, and other physical conditions clearly not mental in nature, were mentioned with more frequency in the male family histories. This may be related to the mention of class issues in the family histories as well. Obviously staff were concerned with the earning power of the men in these family histories. Mentioning physical ailments that might reduce employment time or ability to work might be another way to bring class into the picture for males. Since the "cost" of supporting a feebleminded population was a concern to the proponents of eugenics, it is not surprisingly to find mention of economics in the presentation summaries of the patients.

In terms of our first goal, there really do not appear to be clear differences between male and female family histories over the decades. There are some subtle differences, but generally the themes are the same for the two groups. This leads us to our second goal, discovering whether differences in the construction of the feebleminded between the decades exist.

There are no real changes in the constructions. In the thirty or so years that the institutions have been constructing these write-ups, they have not changed their style of writing nor the content. They are still asking patients the same questions. They are still documenting the same types of behaviours, symptoms, and conditions. They are still recording the class position of fathers and husbands. They are still documenting "possible fits" of siblings. They are still using the same phrases and descriptions of the people they are dealing with. One could easily plant, for example, write-ups from 1953 or 1967 in the 1930s and not notice a difference.

This is noteworthy for several reasons. First, if the written constructions of family history have not changed significantly in thirty years, this means that the 'demon' that the institutional staff is looking for has not changed either. They are still medicalizing the same social problems. They are still labelling as deviant the behaviours they labelled as such in the 1930s. In terms of the construction of the menace of the feebleminded, the definitions have not changed. What was threatening in 1930s is still threatening in the 1960s.

Second, there are implications for the social construction of the process or rather the 'apparatus' that is operating during this time, more specifically, the mental health system that includes the institutions and the Eugenics Board. The two are implicated together, since overlap in membership at the meetings and the running of institutions (superintendents and doctors of institutions attending the meetings) means that communication between the groups was likely frequent. The institutional staff knew what the Board was looking for in terms of the clients who should be presented. The implications for the construction of this apparatus are that these mental health system workers (Board included) were not paying attention to changes in their professional field that were occurring around them. Eugenics theory had been disproved during this time. The horrors of Nazi Germany and its eugenics program had been exposed. Yet, the mental health system continued as it had before these events occurred.

It is difficult to believe that medical professionals and academics were not aware of the changing world around them. Early on in the Eugenics meetings, academic articles, books, and newspaper articles from around the world were read and discussed. We mentioned in the section on the 1930s how the Board had an educational interest and was closely associated with the University of Alberta. Graduate students worked with Board data. A doctor from New York City attended a Board meeting. These were not people cut off from the rest of the rapidly progressing world. Yet, their own work was stagnant and reactionary.

This raises many questions regarding the construction of the mental health/Eugenics Board apparatus. Were the participants really so caught up in their own work that they were oblivious to the advancements around them in terms of medical and social theory and policy? Or were they caught up in the momentum of the outdated eugenics movement to such an extent that there was no stopping them? Had the movement and their activities developed a life of its own? Had the underlying prejudices, which we saw in the 1930s, become codified over time? Had the organizational structure surrounding the Eugenics Board become so entrenched and efficient that the people working within it were blind to these inconsistencies? Did the rationality and rationalizations become greater than the cogs in the machine? Or, alternatively, were they aware but arrogant to the point of thinking that they were right and the rest of the world (with the exception of a few American states) was wrong? I will come back to these questions in a later chapter.

Sexual History

The 1930s

We have just seen that one theme that emerged from the family history section of the presentation summaries was sexuality. This is interesting because there was a section of the presentation summary titled "sexual history". The sexual history "variable" is similar to the family history "variable" in that it too, is composed of paragraphs written by institutional staff members and recorded on the presentation summaries. Sexual histories are worth analyzing because of the importance accorded sexual behaviour and 'misbehaviour' during the reign of the Board. First and foremost, sexual behaviour is directly related to reproduction. Since the Eugenics Board was concerned with the reproduction of "inferior" members of the race (who purportedly reproduced at a faster rate than 'normal' people), it follows that they would be concerned with the sexual behaviour of these people. Secondly, the Eugenics Board and the institutions, as we have seen so far, were very concerned with behaviour, particularly moral behaviour and deviant behaviour. Sexual behaviour is one of the areas where morality and deviance come into play. We see this very clearly in the sexual history information recorded by staff in the mental health institutions.

What follows is a description of the themes that emerge from the sexual histories of males and females presented to the Board in the 1930s. Following this is an analysis of the implications of these histories for the social construction of the social problem. Then we look at the sexual histories for the 1950s and 1960s.

In a significant number of male and female cases presented in the 1930s, there is nothing "wrong" sexually with the patients. In 52% of female cases there is either nothing wrong sexually with the patient, the patient's life is 'normal' and marriage is happy, the children are normal, there is no sex interest, or there is no information recorded. For males, the number is lower, but still high: 44%.

Promiscuity and Illegitimate Children

It is impossible to read the sexual histories without getting the impression that the majority of the females presented to the Board had some history of "promiscuity" as defined by the institutional staff members writing the reports. "Promiscuity" is definitely a concern. In fact 32% of the 125 female sexual history write-ups make some mention of promiscuous behaviour as opposed to other sexual delinquency. Often there is mention of illegitimate children, as a confirmation, it seems, that the patient is indeed promiscuous. "History of sex interest and promiscuity. History of two pregnancies. Was admitted previously on account of sex delinquency" (185). This case appeared before the Board early in 1930. Promiscuity appears to have been a part of the construction of the feeblemindedness problem from the very start. Another patient's sexual history (again, early 1930) reads as follows: "Promiscuous: yes. Has been for sometime" (197). Here is another: "Apart from her sexual promiscuity, there is no history of immorality and no complaints of *other immoral behaviour*. Patient has had six children, all by different fathers…" (259)(italics added). This case appears to be an admission on the part of the author that immoral behaviour is in fact a concern of the Eugenics Board and reason for presentation. People were presented to the Board on the basis of their *immoral* behaviour. This is outside the scope of the Sexual Sterilization Act. Another patient "admits sexual indiscretion with four or five different boys" (403). Yet another patient "has no sexual control at all and is a menace wherever she is placed" (409). It appears that an ability to 'control' one's sexual desires is the standard for behaviour that females must strive for. This write-up hints at the expectations of females at the time. Appropriate behaviour for women includes sexual restraint. As with the family histories, there are many "reports" of promiscuity and women who are "said to have been" seen with several men. Again, we are led to question where this information is coming from. We are also left wondering exactly how "promiscuity" is defined. It seems to include sexual activity outside marriage, but also any type of sexual behaviour, suspected or actual.

Promiscuity emerges as a theme with the males as it did with the females above. This theme is mentioned in 29% of the 115 male cases from the '1 in 5' sample in the 1930s. The first case in 1931 states that the patient "…has been quite sexual, living with prostitutes and other women" (245). Interestingly, it is not referred to as "promiscuity", but rather as behaviour that is "quite sexual". However we soon find male patients "admitting" promiscuity (343) and being referred to by the staff member writing the report as being promiscuous (500). One patient even "admits promiscuity with prostitutes" (591). The prostitute issue is one that appears with the male sexual histories but not the female ones. Whenever there is mention of promiscuity for the males, it is usually accompanied with some mention of prostitution; in seven percent of the male cases there is mention of prostitutes.

Abortion

Somewhat ironic is the mention of abortion in the women's sexual histories. Abortion is presented as another strike against them. The irony is that abortion and sterilization can both be constructed as eugenic activity. In principle, the institutions and the Board should be thankful and appreciative that these 'defective' women are aborting their fetuses. By doing this, they are, obviously *not* reproducing. This is, after all, the goal of the movement. The Board, over the course of its existence ordered the termination of several pregnancies prior to sterilization (minute no. 198, 271). Contraception. Abortion. Sterilization. All a means to the same end. But, in keeping with some of the other hypocrisies of the Board, the abortions are recorded in the sexual histories as yet another indication of these women's immoral behaviour. Here is an example: one woman is "married – well adjusted. Husband has been rather inconsiderate, but patient did not protest. Has had five abortions" (265). Abortion is mentioned in three of the 125 female cases in the 1930s. Again, though the frequency of such mention is not high, it is interesting that *any* mention is made of such behaviour.

Masturbation

Patients seem to be judged as immoral for having premarital sex. They are judged for having illegitimate children and/or abortions. We also find that masturbation is a major concern for the people recording the sexual histories. The "ideal woman" it seems, has one outlet only for sexual activity: marriage. Masturbation is recorded as another form of sexual delinquency or irregularity.

One of the earliest cases in the 1 in 5 sample presented in 1930 has the following sexual history: "History of masturbation and untruthfulness. No decided sex interest as yet" (175). Mentioning the masturbation 'problem' registers this patient in the minds of Board members as having a 'sexual history'. This is the first impression we get of this girl. The fact that we read later on that she has 'no decided sex interest' is lost. Adding in the 'as yet' also implies that she *will* probably become a sexual delinquent. A great deal of the construction process has to do also with the way in which the information is presented, and also the underlying scorn or disbelief of the authors that filters through in their choice of words and order of presentation. While masturbation appears as an issue for the female sexual histories (evident in 6% of the 125 cases), it is a somewhat greater concern for men – 14% of male sexual histories mention this behaviour. It may be that women who masturbate are acting inappropriately in terms of gender roles and males who do so might be exhibiting the potential for future promiscuity as well. It is also possible that, given the sexual norms of the time, women were less likely to masturbate.

"Potential" for Sexual Behaviour

Not only were actual or suspected sexual activities recorded in the sexual histories, but the *potential* for sexual activity was also considered a worthwhile entry. No act had been committed. No delinquency had been reported or admitted. Yet, the Board made sterilization decisions based on the *possibility* of a particular behaviour. This trend began early in the 1930s with case 209: "No special sex interest. No history of sex delinquency. Is quite suggestible, *could* be easily led into antisocial conduct." Essentially, this girl had *no sexual history*. But the potential was recorded, based on conjecture, and influenced whether or not she is sterilized. This is a very powerful aspect of the construction process, since we are dealing with hypothetical behaviours. The constructions in these instances are based not on fact but on impressions made by staff members. Another patient is "unmarried and shows no active interest in the opposite sex, but *would probably* respond passively rather easily to approaches" (277) (italics added). This "potential for sexual behaviour or victimization" theme appears for the female cases only in the 1930s: six percent of female sexual histories mention this issue. The issue does not appear at all in the male cases.

There are some cases where it is the parents who request the sterilization operation because they are concerned about the potential for sexual activity or assault of their daughters. "No sex interests shown. No bad habits suspected. [Mother] quite anxious to have patient sterilized because she is getting beyond control, and she may be taken advantage of at any time…"(319). In another similar case, "[foster parents] are anxious to have the operation performed because they realize that the girl is much below normal, and that she is very likely to get into trouble with men…" (331). In these cases the Board cooperated. Since parents made the requests, this made the decision-making process more efficient.

In the case of male write-ups, there is an absence of such a focus on potential behaviour. However, there are instances of parents requesting the sterilization operation to be done because they realize the 'potential' for trouble (337).

Sexual Delinquency

As Offenders

There is one case where the female in question appears to be a sex delinquent in that her actions are illegal. One female "was arrested on a charge of sodomy with a dog and sent to the Convent of the Good Shepherd. In Oct. 1930 was arrested for attempted bestiality, complaints having been lodged by other school children; apart from this no definite sex delinquency is known" (313). It is difficult to make sense of this sexual history. This female it seems, has participated in activities that are considered deviant. Yet the sexual history concludes with "apart from this no definite sex delinquency is known". This is the perfect opportunity for the staff member to present the case for sterilization based on aberrant behaviour, but the author chooses instead to minimize the behaviour of the patient.

Another girl is considered a sexual offender (though minor) because of her "smut and blasphemy". "Has been too young for sex misdemeanours but is moderately interested in the boys and some smutty notes have been intercepted. Smut and blasphemy made up most of her temper outbursts" (629).

There is much more mention of criminal behaviour and sexual assault in the sexual histories of the male cases. Six percent of male cases exhibit such behaviours. This is very different from the female cases. For example, one patient "practised elicit sexual offences. Misled other children" (379). Another patient has been accused by his brother of assaulting his niece (445). One patient appears to have been causing problems within the institution: "…became an active masturbator and on several occasions was found in bed tampering with other boys…" (463). This sexual history is quite telling: "History of unmoral conduct since early life, sex interest quite pronounced. He has also exhibited a tendency to sex perversions. Once sent to Portage La Prairie for sex misdemeanours. One or two episodes since admission to PMI" (725). Still another patient was serving a 25-year sentence for raping a thirteen year old girl (793). And another was "sentenced to 6 months at Ft. Saskatchewan in October 1935 for buggery" (1230). These are only some of the examples of criminal sexual behaviour on the part of some of the male patients in the sample. Criminal behaviour does appear to play a significant role in the construction of the social problem, particularly for males. This might be influenced somewhat by the criminal status of some homosexual behaviours.

As Victims of Assault or Abuse

There are several reported instances of sexual assault, abuse and incest in the female sexual history write-ups (8 of 125 cases, or 6% of female '1 in 5' cases presented in the 1930s). These instances are definitely within the realm of what would seem "relevant" reporting for this part of the patient history. The problem with these reports is the way in which they are presented. In most if not all of them, the victim, the woman, is made to sound as if she was an active and willing partner in the incident. As an example, one patient apparently "allowed a man to take advantage of her" (301). This is an oxymoron – how can you 'allow' someone to force himself on you? Taking advantage of someone implies it was against someone's will. Similarly, another patient, "at 15 was implicated in sex irregularities with an old man who had to stand trial for carnal knowledge…" (906).

Incest also appears in some of these girls' sexual histories. One patient's "last sex experience was with an uncle" (391). For another, she "had intercourse with her brother before she was into her teens and has been promiscuous since the age of eighteen" (409). Again, the terms "sex experience" and "had intercourse" seem to imply the female was a willing partner in these incidents. In the Board's eyes, this style of presentation might indicate promiscuity as opposed to victimization.

Social Behaviours

As with the family histories discussed in earlier in this chapter, the sexual histories also witness a focus on social behaviours that reach above and beyond sexual concerns.

Marital failure

Comments are made about the patients' marital situations including discord in the marriage, abuse, alcoholism, and common-law status. "Normal in sex trends and activities. Married life a failure" (227). This woman is ***normal*** in terms of sexual behaviour. Her unhappy marriage has no place in this sexual history section. It plants the seed of 'failure' in the minds of people reading it, failure in an aspect of her life that is social and not sexual. Or, at least not sexual in the sense that it should be the "legitimate" concern of the Eugenics Board. People are not to be sterilized because they are 'failures at marriage'. Separation and divorce also enter into the sexual histories of several of the male and female patients (1495; 1573). Nonetheless, marital failure emerges as a concern in both the male and female sexual history write-ups: 16% of women and 17% of men from the '1 in 5' sample presented in the 1930s have experienced some form of marital failure.

Class, Occupation and Employment

Particularly interesting is the way in which social class issues enter into the male and female sexual histories. There was a category on the presentation summaries designed to capture the patient's occupation. However, coding this category for this project was very difficult and so was eventually omitted. In other words, there is no real data on occupation, in the 'formal sense'. Rather, I had to interpret what was said in the presentation summaries regarding this characteristic. In other words, class was not precisely identified in the same was as religion or ethnicity. It is interesting then, that despite the fact that there was a category for occupation on the presentation summaries, employment, occupation, and social class-related comments appeared in other areas of the summaries as well. What this tendency appears to signal is the influence of social class in the construction of feeblemindedness.

What a husband or wife's occupation or employment status has to do with a patient's sexual history is difficult to ascertain. It entered the family histories, which were supposed to be concerned with genetic disorders. Now, we see class entering sexual histories, which are intended to provide information about reproductive behaviours. It appears that social class is a master status and that sterilization decisions were often influenced by this factor. Class, poverty, unemployment status or occupation are mentioned in eight percent of female cases and three percent of male cases from the '1 in 5' sample presented in the 1930s. Again, while these percentages might appear *in*significant, what *is* significant is that these mentions were *in addition to* the official social class category on the form.

The first mention of husband's occupation occurs in 1934: "…husband is away a good deal as he is a traveller…" (512). In 1935, we see more frequent mention of specific occupations and employment statuses. One patient is married to a shopkeeper (841) and another to a miner (847). In 1936, we find that one patient's "husband has been fairly regularly employed" (948). Another patient has a "sort of ne'er do well" who is "at present working on the railway section" for a husband (971). One patient and her husband "have not been successful economically" (1212). One male patient is married to a "Scotch waitress" (743). Another "had to apply for relief in Feb. 1938" (1375). There is more mention of class issues in the female write-ups, but it is usually the employment status of the husband or father that is the focus. So even though men's write-ups exhibit less mention of this issue, it is still ultimately men who are the focus of such class concerns, likely because men are the primary breadwinners for themselves and female patients.

Race/Ethnicity

Race and ethnicity enter into the sexual histories of two of the women in the 1 in 5 sample. One woman is "married to an Indian on the reserve" (307). This is all that is written for her sexual history. The other case where race is mentioned is the case of a woman where "late in 1934 and early in 1935 she was lured into the establishment of a local chinaman and sexual irregularities took place. She became pregnant…" (912).

There is more mention of ethnicity in the sexual histories of the males. Some send money to families back home in the Old Country or Poland. One male is married to a Ukrainian girl, who sadly for him, turned out to be a "nagger".

There are other gender differences as well. It is interesting that with the male cases, there is frequent mention of venereal diseases. Such diseases were never mentioned with the female cases. In most of the male cases where promiscuity and/or prostitution are mentioned there is also a comment on some sort of sexually transmitted disease and the treatment (if any) for it. For example, "admits having sexual experiences. G. C. is denied but there is a history of such from the University Hospital in 1932" (677). Another patient "admits frequent sexual irregularities and was treated for syphilis in France in 1917" (894). Yet another "admits 2 heterosexual experiences. Contracted G.C. says that he treated himself" (995). Some mention is made of sexually transmitted disease (or the denial of such disease) in almost 20% of male cases.

There are also instances of exhibitionism within the institution that are mentioned in the sexual histories for males. This theme does not appear in the female write-ups. One patient "has on a number of isolated occasions furtively stripped himself and paraded the grounds naked" (531). About one patient, the staff member writes the following: "his actions on the ward would indicate that he may have the idea that he is a woman, as he seems to be making love to one of the other male patients" (659). For another patient, appears that "there have been sexual irregularities of a homosexual nature" (1013). In six percent of male cases, but in none of the female cases from the '1 in 5' sample presented in this decade there is mention of exhibitionism, bestiality or homosexuality, which all seem to carry the same negative weight of sexually deviant behaviour for the staff.

The 1950s

The same general themes from the 1930s continue to appear in the 1950s. There is frequent mention of promiscuity and illegitimate children, abortions, masturbation, "potential" for sexual behaviour, marital failure and discord, alcoholism, sexual delinquency and class position. Consistent with the 1930s is the fact the in the majority of cases, patients exhibit what is referred to as normal sexual interests, are happily married, have "normal", healthy children or have no interest in sex. Sixty-six percent of females and 60% of males fall into these categories. In these cases, it might be safe to assume that feeblemindedness was the reason for presentation.

Some other issues that emerge rather infrequently, but are still worthy of mention, are the use of contraception by the women, infidelity, and details on premarital and extra marital experiences. Also there is more mention of women and girls who are "normal" in terms of their sexual lives, normal meaning having an average interest in the opposite sex, being married with children. There is also more mention of girls and women being "very interested" in the opposite sex. Another concern that appears in the sexual history write-ups is a concern for institutional order, girls who are engaging in homosexual activities with other, younger girls. Although there is mention of promiscuity, this theme does not seem to have the weight of importance that it did in the 1930s. This might be influenced by the fact that in this decade it is younger girls who are being presented, girls who may not actually be sexually active or "promiscuous" yet. There is less focus on *mothers'* sexual histories and *their* promiscuity.

As with the female sexual histories, the male sexual histories of the 1950s cover similar topics to those of the 1930s. The same themes continue to emerge: masturbation, crime in the form of assault and incest, marriage, children, marital problems, homosexuality. New issues that emerge in the male cases are institutional order (as with the females), institutional efficiency, education of children of the patients, and also more frequent mention of normal or average interest in the opposite sex. As in the 1930s, there is little or no mention of illegitimate children of the patients. This too, might be a result of the younger ages of patients being presented in this decade. We do not see parents requesting the operation as we did in the 1930s. One concern that does appear more pronounced in the 1950s, for both genders, is the concern with institutional order. We read many more histories where males and females are involved in sexual exploits within the institution. As such, it appears that this new concern has entered into the construction of the problem for institutional staff.

Interestingly, there are only three cases of recorded promiscuity for males, while promiscuity emerges in as a theme in 26% of female cases. We also see for the first time, two male cases where the "potential sexual behaviour" of the patient is a concern. Although this had been a concern for females in the 1930s, it did not appear in any male cases in the same time period. In addition, while sexually transmitted diseases received mention in the male write-ups for the 1930s with some frequency, in the1950s there is only one case where such a concern is recorded. Again, it is possible that this finding is related to the younger age of patients presented during this decade. Because they were younger, it is more likely that as a group they were less sexually active than patients presented in previous decades. Finally, social class continues to be a concern in the female cases (8% of cases) while it does not appear at all for males.

In general the same themes appear. However, it deserves mention that the frequency of the kind of detail we saw in the 1930s does not appear with the male sexual histories in the 1950s. The majority of the male sexual histories are now one-line sentences that read as follows: "patient shows no interest in the opposite sex" or some variation on this general format. In fact, of the 98 male (1 in 5) cases presented in the 1950s, 57 cases[1] are of this format. In other words, the majority of write-ups for males for this variable indicate that there is either no interest in females or no information available. The remaining cases mention details of marriage and children, but there is not the detail we see in the female sexual history cases. Overall, for the male sexual histories, there is either no information, mention of criminal sexual behaviour (assault, incest) or institutional misbehaviour of a sexual nature (homosexual or heterosexual).

The 1960s

As with family history, the sexual history write-ups in the 1960s are also quite similar in format, style and content to those of the earlier decades. We observed that, in the 1950s, the sexual histories of the males became much shorter in length, while the female histories seemed to grow in length and detail. This trend continues in the

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[1] This does not include the cases where nothing was written or no information was available. There are 9 such cases.

1960s. The average length for a male write-up in the 1960s is about two or three lines. For females, the average is about eight lines. This is because female sexual history write-ups include more details about all aspects of the female's life. As we summarized earlier, it seems that all that is female is in some sense sexual, even for these younger female patients. In the female sexual history write-ups we read about ethnicity, religious concerns, abortion, husbands' and fathers' alcoholism, contraceptive use, worry on the part of the patient about becoming pregnant, and abusive husbands, to name a few topics. These types of social concerns are not mentioned in the male write-ups. Another glaring difference is the mention in the female sexual histories, but not in the male histories, of economic situation and occupational status. In this sense, the female histories have not changed much over the years, but the male sexual histories have. The male sexual histories have become very succinct, straightforward accounts of male sexual behaviour (as we presume the sexual histories should be). Has this male had intercourse? Is he sexually delinquent"? These appear to be the questions addressed in the male sexual histories.

There is more mention in the male sexual histories of what one might consider to be "petty" sexual delinquencies. Examples of this behaviour include the boy who lifted up his cousin's skirt (4310), or another one who "did chase and frighten little girls in his neighborhood" (4305). There is of course the boy who came to RCMP attention for stealing "approximately 100 pairs of women's panties" (4485). It may be that we find more of these antics among the male patients of the '60s for the simple reason that during this decade more children were presented to the Board. This would explain the lack of male sexual histories/activity since males mature more slowly than girls. As well, this could explain the lack of economic information included in the male sexual histories. These are boys who are too young to be working and have established occupations. For girls, who marry younger because they mature faster, economic status might already be a reality at a younger age. Regardless, economic status has no place in a sexual history – for either sex.

Related to this, it appears that the "potential for sexual behaviour" is still a greater concern for female patient histories. In only three of the write-ups for males (about 3%) is there mention of such a concern, but for females, close to 10% of the write-ups contain reference to such potential. Promiscuity remains a concern primarily for female patients (23%) while it is barely mentioned for males (2 cases out of 77). For males, the concern with masturbation we saw emerge in the 1930s has become almost negligible (3 cases out of 77). For females, the concern with masturbation has also decreased since the 1930s (6% in the 1930s, down to 3% in the 1950s and 1960s).

There is another important difference between the sexual histories of the patients presented in the 1960s as compared to those of the previous decades. Starting in the early 1960s, there is a pattern of mentioning parental opinion on sterilization. If the parents have consented, this too is written in the sexual history. This is likely related to the development of the new form to be filled out by parents when admitting their children to an institution (discussed earlier). At any rate, a typical sexual history might read as follows: "Patient has shown an interest in the opposite sex and his mother gave her consent to sterilization at the time he was admitted" (4390). Or, somewhat contradictory: "Patient shows no undue interest in the opposite sex. His parents have given their consent to sterilization" (4525). A write-up like this makes us wonder how important sexual history really was to this whole process.

Usually, parental response to sterilization is recorded, even if consent has not been granted. An obvious difference between the sexual histories of the 1960s compared with the other decades, is this new-found concern with consent documented in the sexual history. There are even two instances where parental consent is discussed with regard to testicular biopsy. It may be that the institutional staff and the Eugenics Board are more aware of legal issues and the importance of consent.

What are some of the conclusions we can draw from the above discussion? For females, feeblemindedness was sexualized by the institutional workers. We get the impression from reading their sexual histories that many of these women are "mentally defective nymphomaniacs". They either actively seek out sexual relationships with many men, and have illegitimate children, or they masturbate. The bottom line is that they cannot, it seems, control their lusty sexual thoughts, drives and behaviours. As one sexual history write-up says, they are a "menace" because of their uncontrollable urges. It *must* be that this uncontrollable sexual behaviour is linked to their "mental defectiveness", therefore they are good candidates for sterilization. Even when it is very likely that men, usually older men, forced themselves on these women, it is implied that the women "asked" for the assault or attack, or at the very least were willing participants.

Feeblemindedness is sexualized, but we also see the same thing happening to a certain extent with social class. In other words, class too is sexualized. These are *poor*, dumb women who are oversexed. Class descriptions, whether they describe the couple's financial hardships, or the occupation of the husband, are all making the same point: poor people have lots of sex and lots of kids who are usually mentally defective. It is *poor* women who have the most uncontrollable sexual urges.

A general theme emerges involving women who fall outside the realm of 'appropriate' female behaviour for the 1930s. Girls and women who masturbate are deviants, as are those women who live in common-law relationships, leave their husbands, end pregnancies through abortion, or have premarital sex. All of these behaviours are considered worthy of mention in the sexual histories; they are worthy enough to be considered part of the social construction of this social problem. There is a strict criteria for proper feminine behaviour, set in place by the middle and upper-class female moral entrepreneurs of the 1930s, and anyone who does not fit this mould is likely to be targeted as being deviant.

Patriarchy also figures into this analysis. "Proper women" were obedient to their husbands and focussed on being good wives and mothers. There are several instances in these sexual histories where patriarchal themes emerge. Patriarchy is apparent in the cases where the husband provides information on the wife's sexual behaviour. This information enters the sexual history despite the questionable reliability or validity of the testimony. It appears that if the 'husband' said it it must be true. The woman has little agency; the authors of the write-ups trust the husband's word over the patient's own. In one case, "the husband reports that she has always been suspicious in nature" (1158). Unfortunately the person writing this report felt it necessary to include this testimony of a husband who spent 22 months in prison for embezzlement. After this she left her husband, who was still called on to comment on her sexual history!

The analysis also reveals certain inconsistencies in the reporting behaviour of the staff members. These same inconsistencies occurred with the family histories as well. Some of these sexual histories are subject to change. In other words, people can change on their own, without sterilization. As with the family history where a mother had a nervous breakdown, but then recovered, we also have a sexual history where a woman was promiscuous, had an abortion and an illegitimate child but is now happily married (1073). This is written in her sexual history, so it is obvious that these authors were aware of the changing nature of human behaviour. This however, did not seem to influence the construction of the problem in any significant way. "Curable" or not, these people were to be presented for sterilization. Past "mistakes" follow them regardless of their own rehabilitation.

There are qualitative differences between the construction of the female sexual histories and the male sexual histories. While many of the 'themes' are very similar and the method of presentation is similar, overall there are some significant differences. These differences say much about the different ways in which being female and male were perceived and constructed during the 1930s, the 1950s, and the 1960s.

As with the male family histories there appears to be an underlying tendency to 'forgive' or 'make excuses' for these wayward males. For example, the first case where sexual history is recorded appears early in 1931. The write-up on sexual history (245) goes into great detail describing how this man's wife died of influenza in 1918, how their child died a few years later, how he then spent some time in jail, and since then has been living with an undesirable woman who twice gave him gonorrhea. They had a baby together and that baby also died. After reading all of this, the reader cannot help but think that the poor man deserves a reprieve from all his suffering and if "living with prostitutes and other women" will do that for him, well, then, why not? How can we judge someone who has suffered so much? In documenting all this tragedy, the writer of the sexual history has, in fact, steered us away from the issue of his *sexual* history and instead has focussed our attention on his *tragic personal* history. Surely there were many women who suffered similar fates, but their stories did not seem to receive the attention that this particular story did.

This general underlying tone is likely a reflection of the patriarchal society of the time. We see hints of this type of thinking throughout the male sexual histories. When there is marital discord, usually something is written about the wife being a nag or the wife being unfaithful. There is a detail regarding the marital discord that does not typically appear with the female cases. This detail usually blames the woman. Women seem to be blamed for many of the male problems as revealed in the sexual histories. Often the focus in these sexual histories, in fact, turns the histories into an account of the wife's problems. Here is an example: "…Was married at 23 years but his wife proved unfaithful and he left her several years later, Knows nothing of his wife's recent whereabouts. His wife had one illegitimate child and twins who died at birth" (494). Most of the space in this write-up is focussed on the wife and *her* 'misbehaviour'. The impression? Poor man – how did he get mixed up with *her*?

With the female sexual histories, even in cases of apparent assault, the female victim was made to look like a consenting party, even if she was considerably younger than her assailant and even if the attacker served time for the incident. There is an instance of a male being a 'victim' of such an incident. This patient is "not fond of the opposite sex but *has been seduced by older women*" (561) (italics added). There is no question that this young man has fallen prey to the older, evil women. Why is that? With the cases of female victims, they seemed to know what they were doing, and even their being overpowered was constructed as a fabrication on their part. Women in these male sexual histories are being constructed as the evil, negative influences on the male patients' lives.

Finally regarding patriarchal biases, is the case of an assault. Sexual assault was discussed above, but what is significant about this one particular case is the presentation of the details. In the presentation, the perspective of the staff member seems to come through very clearly. "Of late he has developed a definite interest in sex, and recently attacked a young girl. Aside from the sex problem he has given little actual trouble" (1608). From this write-up we can infer two things. First, sexually assaulting a young girl is merely a "sex problem". It is not a criminal offence. Secondly, having dismissed this 'problem', we find that he really has given little *actual* trouble.

This is the type of inconsistency that appears in the construction of these sexual and family histories. Masturbation is treated as a crime, but a sexual assault is dismissed. Furthermore, it appears that the constructions differ for males and females, and that patriarchal attitudes do seem to play a role in the construction process. This affects the outcomes. Overall, more women were sterilized. From this brief look at the initial years of the social construction of the problem of feeblemindedness we can see why. Women's own behaviour was constructed as sleazy and whorish – if you were outside the norm for appropriate conduct you were in trouble. But even when staff wrote about male behaviours, women still were implicated in the evil aspects. Women were not only the reproducers of bad blood, but they were out there cheating on husbands, nagging husbands and making them miserable, and generally failing to contribute to the smooth functioning of society. It seems that women were either portrayed as sexual beings, as "bitches", or both.

Conclusions

What do these sexual histories tell us about the social construction of the feebleminded problem and of the mental health institutional apparatus? It is apparent from the family and sexual histories of the 1960s that the social construction of the problem has not changed dramatically from thirty years earlier. Females are still defined primarily by their sexuality. Their sexual histories are much more detailed and cover aspects of their lives, of which the relevance to their sexual behavior is tentative at best. There is a stricter, more businesslike approach to the male sexual histories. This could be due to the different construction of male sexual history, one that is less intrusive and judgmental than that for females. But this tendency might also be an artifact of the age of the patients being presented during the 1960s. We also suggested that male and female adolescents, while in the same age group, because of different maturity levels, might be at different stages of their sexual and social development. At any rate, the style and content of sexual history presentation on the part of the institutional staff has not changed significantly over the years.

In terms of the construction of the problem and the eugenic institutional apparatus, there is a very close link between the findings discussed above and the Minutes of the meetings for the 1960s. The Board was described in Chapter Seven as becoming much more cautious in its dealings with patients and their families. The inclusion in the sexual histories of discussions with parents (and spouses) regarding consent confirms this cautious tendency of the Board. The cases where consent is discussed with family members invariably are cases of patients who have been diagnosed as "mentally defective". According to the 1937 Amendment to the Act, such consent is not necessary. Yet the institutions are going out of their way to speak with parents about the sterilization and their feelings about it. They must have been getting their directions from the Board, a Board that at one time cared little about what parents or anyone else had to say about sterilization.

Why this change in policy/procedure? It is difficult to tell. We saw evidence that the Board is becoming more cautious and careful in the 1960s.We saw this in the Minutes. We also now see it in the institutional write-ups. There seems to be a general re-evaluation of the institutional apparatus as it was operating. This concern with consent might actually prove that the Board, despite its stagnant ways, really *was* aware of what was going on around it in the wider society. Maybe the Board members started to have reservations about the ethical aspects of the Act and its Amendments. Maybe interest group activity in opposition to the Eugenics Board was growing. For whatever reason, in the years leading up to the repeal of the Act in 1972, we see more and more evidence of the cautious Board that first showed its face in the Minutes of the meetings in the late 1950s and which became more pronounced in the 1960s. Even the sexual histories, which show remarkable consistency from the 1930s through the 1960s, begin to show differences in this regard.

Chapter 9
Summary and Conclusions: Laying Blame?

> "The government of Alberta expresses its profound regret to those who have suffered as a result of being sterilized under this (Sexual Sterilization) act. We are compensating these victims and finding ways to treat these people in a sensitive, fair and equitable manner. We are doing the best we can for all concerned to make things right and to correct, as much as possible the wrongs of many years ago. It is important that this very sad chapter of Alberta history is now closed for the hundreds of victims. The compensation can never fully deal with the trauma suffered by these individuals."
> (the Alberta Government's statement, Edmonton Journal, November 3, 1999).

We have covered a great deal of material in the past several chapters. It is time now to bring the story of eugenics in Alberta together and to make some concluding statements. I begin by returning to the original research questions posited in Chapter One, to see if we have in fact done what we set out to do. Following this, I comment on my role as researcher, and how this has affected the research findings. Next, I try to answer two difficult questions which are present throughout the thesis: how could this happen in Alberta, and how could it go on for as long as it did? Finally, I conclude by commenting on the role of history, the role of professionals in making that history, and how this study has relevance for the present and future.

We began in Chapter One and continued in Chapter Two to answer the first set of research questions:

> What was the general social and political milieu at the time of the eugenics movement? How did this atmosphere contribute to the identification of certain groups who were defined as being "problem populations?"

We saw that eugenic theory was an international phenomenon. In Alberta and Western Canada, several notable citizens and interest groups actively campaigned for the segregation and then the sterilization of the so-called "feebleminded". Emily Murphy, J. S. Woodsworth, the United Farm Women of Alberta, the Canadian National Committee on Mental Hygiene, the Bureau of Research in the prairie provinces all contributed to the claimsmaking process. In addition, we witnessed the importance of the news media to this process. Newspapers, magazines, and books claimed that sterilization was the answer to this rapidly spreading and increasingly dangerous social problem. Immigration issues played into the push for sterilization policies. Social class played a role in how the claimsmakers made their claims. The claimsmakers and media at the time played on people's fears, and used exaggeration techniques and questionable statistics to make the claim that the feebleminded were a threat to the survival of the human race.

It is clear that some well-educated, primarily Anglo-Saxon, middle and upper-class groups had the power to construct an image of the threat posed by less advantaged groups. They were able to use their power and influence to both create this image and then to enact policies to address their concerns. Often the targets of these policies were people deemed different from the social control agents. In other words, individuals chosen for institutionalization and presented for sterilization portrayed characteristics that fit the deviant stereotypes during this time in Alberta history. Individuals sterilized by the Eugenics Board were labeled as feebleminded, but also as dysgenic, unfit, unintelligent, uneducated, economically disadvantaged, sick, or otherwise threatening to the status quo.

An Overview of the "Eugenics Machine" in Alberta

It appears that for many reasons Alberta was "ripe" for a Eugenics Board and a eugenics program. We saw in previous chapters that there were two primary components to the process, the mental health institutions and the Eugenics Board. Each made a different but significant contribution to the process. This leads us to the second set of research questions asked initially.

> How did this happen? How did the Eugenics Board carry out its mandate? Who was the Eugenics Board? How did it operate? Once in place, how did the Eugenics Board contribute to the construction of the problem? Did the Board's activities change over time? If so, how did they change? How did these changes contribute to the construction of the problem?

The Board, we saw, began as a cautious group of educated people who wanted to 'do good'. They wanted to help people and society in general. Their initial concerns (expressed during the initial meetings) were to expand their operations so that they could effectively control the "dangerous classes" and the "feebleminded".

However, during the 1930s they were also concerned with patient welfare, with getting the consent of patients before operating, with conducting follow-up reports after sterilization. This changed in 1937 with an Amendment to the Act that rendered consent unnecessary for mental defectives.

Throughout the 1950s and 1960s there were some subtle changes in the Board's approach to its mandate. The Board appeared to become quite confident. Patient concerns, parental concerns, government concerns were quashed. The Board developed a life of its own. Certain individuals became more powerful, and at times aggressive in their dealings with patients and parents. Again, expansion was an issue during this era, the desire to control more and different types of people. The Board had become more and more effective in carrying out its initial goals set in place in the 1930s. By now, there was complete disregard for the fact that eugenics theory has fallen into disrepute in the scientific community; no mention was made of Nazi Germany and the horrors that occurred. The eugenic machine continued to forge ahead, apparently oblivious to reason and criticism.

In the late 1960s there appears to be some loss of confidence in the Board. It assumed a cautious stance again (as in the 1930s). It is as if the Board was beginning to realize that perhaps there was rising opposition to their activities. We saw more instances of parental questioning and confrontation with Superintendents, who then reported some of these problems to the Board.

The Board Minutes do not indicate any significant signs of trepidation on the part of the Board in the years leading up to the repeal of the Act. At the meeting on February 8, 1952 there was mention of seeking to amend the Act to include "hereditarily deformed persons", but after consultation with the "Departmental authorities" who "did not deem it advisable to re-open the *Sexual Sterilization Act* at this time", the matter was dropped. This though, was twenty years before the Act was repealed. At the last Board meeting, on February 22, 1972, the only mention made of the possible impending repeal of the Act is as follows:

> The Chairman spoke briefly to the members of the Board in regard to the proposed repealing of the Sexual Sterilization Act at the next sitting of the Legislative Assembly. The Chairman made his views known and will answer the letter

> received from the Acting Director, Division of Mental Health.

In other words, from the Minutes that are used in this study as a window into the construction of the eugenics problem and process, it appears that the Board may have perceived itself to be operating in a vacuum to some degree. They do appear oblivious to some extent to the fact that eugenics was no longer seen to be an appropriate response to people with disabilities and mental illness. Perhaps they were aware and did discuss it, but such discussions were not recorded in the Minutes, so it would be pure speculation to comment on their awareness of current scientific and public opinion at the time. I have pieces to this puzzle, but am also making several assumptions. As a social constructionist I am trying to reach some conclusions on the firmest ground available with perhaps the softest of data. Ultimately I do not know how much the Board knew about the impending demise of the Act, nor do I know if they were being overtly criticized and attacked. From the records they left behind, it appears that they were oblivious to it; if they were aware, they were oblivious to the importance of the critique as illustrated by its absence from the Minutes.

What do we know about the activities leading up to the repeal of the Act? After World War II, the German eugenics program became public knowledge when the atrocities that occurred were revealed. It was around this time as well that eugenic theory fell into disrepute as advances in genetics disproved some of the theory's initial claims. But probably one of the most damaging influences on eugenics programs was changing public sentiment about reproductive rights. There was a major transformation in public attitude toward reproductive responsibility in the 1960s and 1970s (Paul, 1995: 129):

> Until then, it was taken for granted that society had a legitimate interest in who reproduced. By the mid-1970s, it was equally taken for granted that society had no interest in the matter. Within two decades, reproduction was transformed from a public to a private concern (1995: 129).

As an illustration of the magnitude of these changes, Paul compares two court cases, the famous *Buck v. Bell* from 1927 to *Eisenstadt v. Baird* in 1972 (1995: 129). We have already discussed the importance of *Buck v. Bell* and Justice Holmes' claim that "the principle that sustains compulsory vaccination is broad enough to cover cutting the fallopian tubes" (1995: 129). In *Eisenstadt v. Baird* the Supreme Court stated that "if the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion in matters so fundamentally affecting a person as the decision whether to bear or beget a child" (Paul, 1995: 129).

In addition to this new respect for and protection of individual rights from governmental intervention was also an emphasis on respect for patient rights in medicine (1997: 129). Also, during this time period, the civil rights and feminist movements were active and influential. Women fought for the right to control their bodies, a fight that would help to put eugenics programs to an end.

Alberta was likely experiencing these cultural, political, and social trends as well. While not much has been written on the repeal of the *Sexual Sterilization Act* in Alberta in 1972, Timothy Christian, for his study, interviewed Mr. David King, a Member of the Legislature at the time of the repeal (1974). According to the report of this interview, the first steps toward repeal of the Act were taken in 1969. David King, as research assistant to the Progressive Conservative Opposition Leader was assigned to examining "existing legislation that might be inconsistent with the party's proposed provincial Bill of Rights" (1974: 30). In 1971, the repeal of the Act was adopted as part of the Progressive Conservative platform. Up until that point, Mr. King investigated various aspects of the Act, including the genetic-medical reasoning on which it had been originally based. When he spoke in the Legislature during the second reading of the *Sexual Sterilization Repeal Act*, he drew on the work of two University of Alberta geneticists, K. G. McWhirter and J. Weijer (1969). Using this information, King suggested that the scientific evidence did not support the province's negative eugenics program (Christian, 1974: 31).

Mr. King also attacked the Act on legal and moral grounds, specifically the exemption from Board members and surgeons from civil liability (1974: 33). As Christian writes, citing the Alberta Hansard:

> The Government's concluding argument was "simply, that the Act violates fundamental human rights". Mr. King objected to the presumption that society, "or at least the Government, knows what kinds of people can be allowed children and what kinds of people

> cannot". The provisions in the Act which allowed the Government to order the sterilization of certain persons without consent was alleged to be premised on a "reprehensible and intolerable philosophy and program for this Province and this Government" (Christian, 1974: 34).

The *Sexual Sterilization Repeal Act* was widely supported at its third reading and was passed.

The above discussion centres on the Board's activities as legislated by a provincial Act. But we also saw that the Board was not alone in the construction of this 'social problem'. Another group of key players in the eugenics story was the mental health professionals in the institutions. Acting as 'feeders' to the Eugenics Board, the staff of the mental health institutions had a crucial role in the sterilization process. The third set of research questions dealt with issues relating to the institutional role.

> Who was targeted by the movement, the institutions, the government and the Board? Are there discernible patterns in who was selected as problem populations over the years of operation of the Board? How do these constructions tie into the activities of the Board? Did the constructions of "appropriate" targets change over time? Did the constructions on the part of the institutions change over time? Were these constructions similar to those of the Board? Did these targeted/labeled individuals exhibit any resistance or agency in dealing with their labelers?

At the same time that the Board was dealing with its own power, consent and expansion issues, the provincial mental health institutions were doing their part to contribute to the construction of the problem. In documenting the family and sexual histories of patients, the staff members of the institutions were remarkably consistent over the decades. Throughout the years the style and format as well as the details covered in the write-ups were very similar. There was a sense of mistrust of the patients and their families. There was vagueness in the descriptions and diagnoses. Economic details entered into family and sexual histories. Criminal behaviour also entered into family and sexual histories. It appears that patient character was being judged by these professionals; there does not appear to be much of a scientific basis to the decision making process. Above all, evidence of "hereditary taint" is noticeably lacking in the majority of cases. Rather, what is most apparent is evidence of socially, morally, sexually and economically deviant behaviour on the part of patients presented and sterilized.

What does this say about the institutional and Board constructions of feeblemindedness? Importantly, it says that the constructions at both stages in the process appear to have been based on arbitrariness and a lack of 'scientific' information. Furthermore, it seems that once the initial format and procedure were developed in the early 1930s, few changes were made in terms of the ways in which patients were selected for presentation and the ways in which decisions for sterilization were made. Whatever changes were made were made in order to bring more people under the purview of the Eugenics Board (for example presenting and sterilizing more children in the 1960s).

Gender

One area where there is remarkable consistency on the part of the "eugenics machine" throughout its years of operation is its treatment of women. There is a strong patriarchal focus to the constructions of feeblemindedness. This focus is evident in one of the initial meetings of the Board where mention is made of a concern for working girls' accommodations in the city. Thus the 'morality' of female behaviour was a focus from the start. Throughout the analysis of both the Board meetings and the institutional narratives, we find additional support for the claim that women were targeted by the eugenics movement. With the exception of the 1930s, where more men were presented, in each decade women were more likely to be presented and sterilized. The probability of a woman being presented while institutionalized was similarly much higher than that for a man. We found cases in the Minutes where women were too ill to consent to sterilization, so husbands were pursued in an effort to attain consent. There was a preoccupation with the issue of whether hysterectomies fell under the domain of the Eugenics Board: was the goal to simply sterilize or could more intrusive surgeries be authorized?

In the institutional summaries we find more evidence of this female bias. Women's family and sexual histories are much more detailed than those of the men. Does length of write-up indicate the building of a 'stronger case' against such patient? Perhaps. What we do see is that, in these sexual and family histories, staff members are far more concerned with promiscuous behaviour and illegitimate children. The sexual behaviour of *relatives* of female patients are included as part of the *patient's* history. Of particular concern to the staff is the sexual behaviour of female patients' mothers. "Immorality", often defined as relatively minor indiscretions (masturbation, writing love notes, going to dances), is more frequently documented in the female family and sexual histories. As Baragar, one of the professionals involved in the system, stated in an academic article: "A word about the moral reactions of the male patients. Information in this respect is inadequate, and the problem of course is not after all so important as in the case of the female sex" (Baragar et al, 1935:905).

Particularly interesting is the manner in which sexual behaviour enters virtually every aspect of the female presentation summaries. To be female is to be sexual is to be feebleminded is to be in need of sterilization. These same patterns do not occur to the same extent with male patients. Over time, we notice that the male family and sexual histories get briefer. Women were more likely to be treated as a feebleminded threat and therefore sterilized than were men.

Part of the reason may involve general patriarchal attitudes, and related to this, the fact that male patients had more agency. In the Minutes, mention is frequently made of males refusing to consent to sterilization. This was occurring so much that in both academic articles produced by affiliates of the Board, mention is made of the tendency for males to refuse to consent to sterilization. "It seems somewhat more difficult to obtain consent from males than females. The reason for this appears to be a subtle one, the male giving the impression that the operation would be a blow to his pride or vanity" (Maclean and Kibblewhite, 1937: 588; see also Baragar et al, 1935: 902).

The institutional write-ups also focussed on class and race issues. We saw previously that descriptions of the economic status of patients and their families entered into the sexual and family history sections of the presentation summaries. We saw also the frequent mention of immigrant or ethnic status of patients. As well, we witnessed the overrepresentation of Aboriginal people in presentations to the Board and sterilizations.

Gender is one instance where the two key players in the sterilization process – the Board and the presenting institutions - were consistent in their construction of the "feebleminded menace". Were there other consistencies? This leads to the question of the relationship between the two players, the Board and the mental health institutions. Did one play a more important role than the other? Was one a leader and the other follower? Were they equal partners in this eugenics 'dance'? It is to the answer to this question that we now turn.

"The Dance": Who was really in charge?

It appears that while the official government body, the Eugenics Board, and the mental health institutions participated in different ways, the end result was the same. Both had a preconceived notion of who it was that needed to be presented and sterilized, who was a feebleminded threat to society. This was established partly within public debates, in part through eugenic theory, partly by the government in passing the *Sexual Sterilization Act*, and by the Board at its formative meetings. It was also established in the minds of the professionals/experts who presented cases to the Board. At any rate, these ideas of who required sterilization did not change significantly throughout the years of operation of the Board.

The Board became stronger and more confident in its convictions and in its idea of who should be sterilized. The "feebleminded" threat became entrenched throughout the years of operation of the Board. For their part, the institutions showed this conception. People were presented and were constructed in ways that were remarkably similar. In other words, the staff "made the case" in the same way, regardless of individual characteristics of patients. If you had a broken marriage, a great aunt in a mental institution, a deceased parent, then you were going to be presented. And your story would be told in such a way that your economic history would enter the narrative as would other irrelevant details. The official "reasons" for sterilization were irrelevant. Once a person appeared before the Board, they were likely to be passed (99% were). The reason really did not matter. It was added to the presentation summary, but likely as a formality. It is possible that the institutional staff were giving the Board what they knew the Board wanted.

What conclusions can be drawn from this? There was a clear idea among Board members and institutional staff about who should be presented (anyone who appeared to be feebleminded or mentally ill, who acted unusually, and had a suspect history). The staff members did their job, they constructed stories using whatever information they could obtain (or whatever conjecture was available to them). The Board did its job too, it passed almost all patients, assigned "rubberstamp" reasons for sterilization, and became increasingly cavalier and confident along the way.

But who led this "dance"? Did the Board set the pace? Did institutional staff lead? Did they take turns? The evidence seems to point to the Eugenics Board as leader. It is true that the institutions represented the first official step in the process. It was the staff in these institutions who decided who should be presented. It was the staff who selected patients for presentation and then proceeded to make the case by writing the presentation summaries. One could argue that the institutions led the way. Realistically they could have stopped this process at any point over the forty years. They could have reported to the Board that none or few of the institutionalized patients fit the sterilization bill. But they did not.

It is because of this fact and others, that the Board was the leader in this dance. It is my view that the Board dictated to the institutional staff what type of patient should be presented and what type of patient would likely be passed for sterilization. It is for this reason that the previous chapters were ordered the way they were. The Board was the leader; it was the first official actor to be established in the eugenics process. Before the Act was passed, the institutions were already operating, but only after the Eugenics Board was created did their role in promoting mental health in Alberta change.

The Eugenics Board set the standard for presentation and sterilization in its formative meetings. It was here that forms were created, particularly the presentation summary form which played such a crucial role in the part the institutions played in this process. The presentation summaries changed very little over the forty years. In other words, the institutions during the entire time of the operation of the Board did not question the format of the forms, did not significantly change the way the forms were filled out, did not significantly change anything about their role in this process.

They continue to go through the same motions in 1971 that were established for them in 1929. This is evidence pointing to institutions as followers in this dance.

In order for a presentation to occur, at least two psychiatrists had to recommend that a patient be presented (MacLean and Kibblewhite, 1937: 587). After the recommendation was made, the presentation summary was produced. What we notice from the attendance at Board meetings and from the Minutes themselves, is the very close alliance between Eugenics Board members and the medical and psychiatric profession. In other words, recommendation for presentation came from the 'higher-ups' within institutions, who were closely tied to the Board itself. Chairman of the Board from its inception until 1965, J. MacEachran was a University Philosophy professor. While the psychiatrists were professionally on an even playing field with some of the Board members, their role as 'feeders' to the Board, as established in the early formative meetings, meant they were 'followers' in this dance, not leaders.

The Board ultimately had to approve everything concerning eugenics, presentation, and sterilization. We saw in the analysis of the meeting Minutes that, at one point, Superintendent le Vann initiated the presentation of children under 12. The Board had final say on this matter and turned down his suggestion – at first. We saw later that the Board did approve such action under certain circumstances: to be decided by individual Superintendents. However, despite the autonomy granted the institutional representatives, approval from the Board was necessary before any change in the types of patients presented occurred.

The fact that the same person remained as Chair for most of the Board's operation leads us to ask if there was perhaps a single 'villain' leading this dance. Would the Eugenics Board have fallen apart sooner had it not been for MacEachran? It is difficult to answer this question based on the information at hand. It was not long after MacEachran's retirement from the Board that it was disbanded. This however, is likely for reasons discussed below. Certainly having the same leader for 36 years would in some way influence the relations between Board and institutional representatives and the consistency in terms of characteristics of patients chosen for presentation. There is certainly something to be said for consistency in leadership.

The leadership of the provincial government of the time similarly did not change significantly for over forty years.

Part of the nature of the relationship between Board and institutional staff likely has to do with the emergence during this time of the medical health professions (psychiatrists, doctors, nurses, social workers). The Eugenics Board was created during a time when the medical health occupations were striving for professional status. We discussed in Chapter Three how science and the development of diagnostic and treatment techniques contributed to the status given these positions. As newly designated "experts", the institutional representatives were working toward permanent professional status. Affiliation with the Eugenics Board would ensure a steady stream of work and a niche in the medical world. As discussed in a previous chapter, part of the permanence of such a niche is the level of uncertainty and indetermination surrounding such jobs. Diagnosing mental illness or defect, writing up presentation summaries, making recommendations for presentation; these are all examples of "expert knowledge" not available to the layperson. In an effort to maintain their newly achieved status, representatives of the mental health institutions would not want to ruffle the feathers of the Board. Rather, quietly carrying out their duties as established in the early 1930s would ensure stability, respect and status.

Within institutions, the superintendents, psychiatrists, and doctors set the tone for business. Nurses and social workers fell into place as subordinates carrying on as expected (Freidson, 1972). Further, when faced with large numbers of patients (and we know that institutions were crowded from the Minutes and the public health records), the tendency was for staff to fall into a set routine, to streamline activities. As a result, there was little time to question orders or to spend much effort investigating claims of patient defectiveness. It was all they could do to keep the wards on the institutions running smoothly.

We have been discussing the main players in this dance, the Board, the surgeons, and institutional staff. But the ultimate initiator of the dance was of course the public who in turn influenced the government that passed the legislation in the first place. Once the process was started, the government reappeared infrequently to make amendments to the Act, to approve sterilization of wards of the state, to make decisions regarding the legality of certain procedures. In other words, the government and politicians in general played a background role in this dance – backup musicians. The audience to the dance was the interest groups and general public, who throughout the forty year dance offered some applause, sometimes booed the dancers, but overall did not get more involved than that.

This leads us back to the question of who was the "ultimate leader" in this story? One answer to the question, the answer offered by this version of the story, is that all players certainly affected the outcome, but the evidence points to a primary role for the Eugenics Board. This leads to the final set of research questions.

Why Alberta and why for so long?

> Why did the Eugenics Board remain in operation for as long as it did? Was Alberta really a hotbed of delinquency, crime and feeblemindedness? Or was the existence of the Board related to other factors? How did the Board itself contribute to its own longevity?

As I mentioned in the first chapter, eugenics theory and eugenics movements were an international phenomenon in the late 19th and early 20th centuries. Several European countries instituted sterilization programs. The most well-known was that of the Hitler regime in Germany. In North America, sterilization laws were also introduced. In Canada, only British Columbia and Alberta enacted sterilization laws. It is estimated that only a few hundred individuals were sterilized in British Columbia, compared to 2834 in Alberta[1]. In several of the United States, sterilization legislation was enacted in the first decades of the 20th century, in most cases, earlier than in Alberta. We saw in Chapter Six that the Eugenics Board used the California sterilization system as a model to follow in developing its own policies. In terms of rates of sterilization, Alberta rates were much higher than the US rate, and were often comparable to the rates of some of the most active sterilizing states. For example, during the 1930s, the annual sterilization rate (per 100 000 population) was 2.05 in the United States, compared to 9.05 in Alberta. In the 1940s, Alberta's rate was also much higher than the US rate (6.21 compared to 1.68). During this time several states

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[1] The records from the sterilizations in B.C. were "lost" (Law Reform Commission of Canada. Protection of Life: Sterilization. Working Paper 24, Ottawa: Ministry of Supply and Services, Canada, 1979)

(e.g. California, Virginia) had rates as high or higher than the Alberta rate. Alberta's annual sterilization rate rose to 6.43 in the 1950s, to 6.56 in the 1960s, and then declined in the 1970s to 3.93. National estimates for the US indicate much lower sterilization rates in the 1950s (1.01), and the 1960s (0.26), although North Carolina continued to match the Alberta rates until the 1950s. In addition, the higher sterilization rates for women observed in Alberta were also observed in the US[2].

These patterns in sterilization likely were similar because of the worldwide trend that was occurring. Eugenics theory was a scientific theory that influenced experts everywhere. The Progressive Era, which contributed to a definition of what was appropriate behaviour, particularly in the case of women, also influenced thinking in North America. There are however, characteristics of the Alberta case that set it apart from others.

First, Alberta (aside from British Columbia's short-lived foray into sterilization policies) was the only Canadian province with a prolific sterilization program. Why did this occur in Alberta, to the extent that it did, and nowhere else? What was it about Alberta society during this time period that encouraged and enabled the legislation and sterilization program to develop as it did? Second, why did the eugenics program continue for as long as it did in Alberta? We already mentioned that British Columbia pursued its sterilization program much less aggressively than did Alberta. Virtually all the other North American jurisdictions allowing involuntary sterilization appeared to have slowed down, if not completely stopping the practice, long before Alberta did so in 1972. As Daniel Kevles notes in his history of the eugenics movement in North America, scientific opinion had turned against the eugenic doctrine by the 1930s, and by the 1950s, "eugenic sterilization also had become offensive to moral sensibilities in most regions of the Western World because of its association, now revealed, with the Nazi death camps" (1997: 221-22).

Without a doubt, the first question, why did this happen in Alberta, is most perplexing. I do not believe there is a definitive answer, but attempt to offer some observations concerning Alberta society at the time and how this may have contributed to the successful implementation of an effective sterilization program. Following this, I attempt to answer the "why for so long" question.

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[2] See Appendix Table 1which lists some selected sterilization rates in various jurisdictions.

Political and Economic Milieu

The United Farmers of Alberta, encouraged in large part by their affiliate, the United Farm Women of Alberta (UFWA), passed the *Sexual Sterilization Act*. The United Farmers of Alberta was a political group rooted in populist ideology; it was built on a belief in grass roots government. The economy at the time was based largely on agriculture. What better group to govern an agricultural prairie province than a political group built by farmers themselves? There is evidence that, despite the fact that Alberta was also a province built on the backs of immigrants, the United Farmers of Alberta actively opposed Canadian immigration policy. The United Farmers along with leaders of the Trades and Labour Congress, Anglo-Canadian bigots, nativists of the National Association of Canada, and the Ku Klux Klan, all attacked the federal government's Railways Agreement which brought thousands of immigrants to Alberta (McLaren, 1990: 65). When the Canadian National Committee on Mental Hygiene's survey conducted in Alberta in 1919 was published in 1921, it seemed to exacerbate the already hostile feelings toward immigrants that existed among Alberta leaders and citizens. The authors of the survey "asserted that the recent wave of Slavic immigrants suffered from high levels of feeblemindedness" (1990: 99). As McLaren points out, this evidence was "seized upon by the anxious defenders of the social status quo" (99). It was after this information surfaced that the UFA, in 1922 at its convention called on the government to draft legislation that would legalize the segregation for life of the feebleminded. They also requested that the government study the feasibility of implementing a sterilization program. It was at this point that the UFWA focused their energies on promoting the sterilization cause.

It appears then, that the early impetus for the sterilization program in Alberta was linked to restrictionist policies and anti-immigrant sentiments. Fears over the protection of land and jobs from 'invasion' by outsiders were exacerbated by the provision of scientific 'evidence' regarding the inferior state of these newcomers. But one would assume that similar conditions must have existed in other provinces, Saskatchewan, for example. The two provinces, Alberta and Saskatchewan, shared a similar population makeup in terms of immigrants, as well as agriculture as the basis of their economy. Both provinces experienced high debt during the 1920s. Why then, did Saskatchewan not pass a sterilization act?

Alberta was different in other respects. In Alberta there was a devastating drought in the southern drybelt between 1917 and 1926, which saw the loss of many lives and farms, and produced expensive irrigation experiments that contributed to the increasing debt of the province (Jones, 1986; Jones, 1998). While the Depression in Saskatchewan was more severe than in Alberta, the latter experienced much deeper debt than Saskatchewan *prior* to 1930 (Finkel, 1989; Richards and Pratt, 1979). This, in part, may explain the very different political routes taken by the provinces. Political differences likely affected provincial differences in terms of sterilization policy.

Alberta was different from Saskatchewan in terms of its allegiance or friendliness with federal politicians as well. This too may have influenced the initial attitudes and opinions regarding certain issues, both among provincial politicians and the public. Only until 1921 in Alberta, but up to 1944 in Saskatchewan, provincial leaders were closely affiliated with their respective federal parties (Richards and Pratt, 1979). In other words, Alberta broke free of federal allegiance much earlier in its history than did Saskatchewan. We see shortly that part of the reason the Social Credit government eventually came to power and retained power for so long in Alberta was because of the West-East antagonism that consistently brewed in Alberta during this time, and on which the party capitalized. Also, early on in both provinces, there was a division in approach to politics taken by the electorate. For example, it appears that Albertans were influenced by the American populist group the Nonpartisan League as early as 1916 (Richards and Pratt, 1979). In fact, in 1917, the UFA government adopted its strategy of farmer supported aggressive state government in pursuit of regional economic development (Richards and Pratt, 1979). This group experienced little success in Saskatchewan. In Saskatchewan, the Liberal premier thwarted any attempts by farmers to organize into a political party by cleverly taking prominent farm leaders into his cabinet, and also by dissociating his party from the federal Liberals.

Probably largely because of the economic situation in the province after the railway was completed, the Alberta economy went into a tailspin (Finkel, 1989) and the United Farmers of Alberta organized. The party originated in 1909 as an economic movement. As such it restricted its political role to lobbying the government for legislative changes to benefit farmers (Finkel, 1989). Class issues contributed to its platform. The UFA embraced the concept of "group government", which refers to representation on the basis of occupation groupings rather than on the basis of residence-based constituencies (Finkel, 1989). Interestingly this concept did not find much support in other provinces, so again, Alberta was different.

Also interesting, and crucial to an understanding of eugenics, was the UFA government's reliance on experts. In fact, the UFA was "unresponsive to the resolutions passed by UFA constituency groups" and preferred instead to "rely upon the views of 'experts'" in the formulation of government policy" (Finkel, 1989: 20). The fact that the UFA passed the sterilization legislation leads to some interesting observations. First, the UFWA had made a resolution regarding sexual sterilization in the early 1920s, almost a decade before the Act was passed. It may have been that once the CNCMH produced its 'scientific' report, and after professionals in the province jumped aboard the eugenics campaign, the government initiated the legislation. Public support was not enough. Expert support, however, made the difference. We come back to the importance of professionals later in this section.

It appears that what happened next in the political arena in Alberta had much to do with the longevity of the *Sexual Sterilization Act*. As Richards and Pratt argue, the UFA illustrates "two social processes that in times of stable prosperity sap the drive of all reform movements: bureaucratic co-optation at the top and political apathy at the bottom" (1979: 31). Once the UFA was in power, and once the economy stabilized, the government became more conservative and illustrated the reactionary side of its administration. Members disillusioned with the stagnant character of the government turned elsewhere. Because the CCF was weak in the province, the obvious other alternative was Social Credit. Again, this was a grass roots movement, but a grass roots *social* movement. As with its predecessor, it would capitalize on peoples' frustration with their economic poverty, their anti-eastern sentiments, and their desire for radical changes (Finkel, 1989). Part of the Social Credit mentality regarding Alberta's role in the Dominion was anti-Eastern sentiment characterized by determination and confidence: "we'll show you we can do it on our own" (1989: 22). Again, there was the feeling that in Alberta people were different from the rest of Canada; it was the experimental hotbed of Canada. The UFA government 'experimented' with sterilization legislation, and Social Credit would continue nurturing the 'radical experimental' ethos, which meant keeping the Eugenics Board in operation.

How did the political climate in Alberta under the Social Credit government enable the continuation of the Eugenics Board and its work? Without getting into a lot of detail on the history and development of the Social Credit government, some generalizations are relevant. First, the Social Credit government, like its predecessor, placed much faith, indeed placed the running of the province, in the hands of professional experts. Of course we cannot avoid a discussion of William Aberhart, leader of the party and government, and his fundamentalist religious role as preacher. While there is some dispute over how much influence this religious factor actually played in his politics, undoubtedly during this "Progressive Era" with an emphasis on the definition of behaviour according to strict moral codes for behaviour, such religious beliefs had some role to play. His religious radio show was very popular; 300,000 people or 65% of the Alberta population regularly tuned in to listen to the premier (Finkel, 1989). As with its predecessor, the Social Credit government tended to turn away from public sentiment in favour of expert opinion.

As well, after campaigning on rather radical grounds, the Social Credit government eventually became conservative and stagnant in many respects. With the Social Credit government also arrived post-World War II prosperity and the lucrative discovery of oil in Alberta. In others words, people were generally successful and happy and did not need to question the government or agitate for change, as had been the case earlier. With prosperity in the province, the government was no longer concerned with reform but rather with the day-to-day administration of the province. Why repeal the *Sexual Sterilization Act* when there was no uproar over it? With the oil boom also came many "out-of-provincers" who moved to prosperous Alberta to find work. Likely many had no idea that a *Sexual Sterilization Act* existed and that a Eugenics Board was actively operating. How could they oppose something they did not know existed? For the government, the goal was now to perfect its administration and to continue to support the 'experts' involved. As Finkel points out, Social Credit was always partial to conspiracy theories (1989: 10), so keeping the *Sexual Sterilization Act* in place likely proved a preventive stance against any problems with deviant populations.

During this time of prosperity and comfort for the Social Credit government, the focus on the day-to-day administration of the government resulted in some tendencies that contributed both to its longevity, and to its reactionary role. As such, these characteristics might also provide a partial explanation for why there were no changes made regarding the *Sexual Sterilization Act*. Much of what followed in the Social Credit party was based on the tone set by its first leader. Aberhart started the regime in an authoritarian manner. "The social credit political theory and the inspirational quality of Aberhart's leadership, which demanded and received the complete submergence of his followers' wills, combined to put any problem of the popular control of the legislature out of sight, or at least in abeyance" (Finkel, 1989: 30). Manning, who succeeded Aberhart, continued with this dictatorship-like leadership (Finkel, 1989: 31). Both leaders were known for being indifferent to "rank-and-file complaints" (58), and a tendency to turn to "experts". The overall impact, states Finkel, was to "remove the democratic and radical aspects in favor of creating an authoritarian party and government" (60). The government was closed to criticism; how could anyone have initiated a repeal of the *Sexual Sterilization Act* under these circumstances?

In addition, the Social Credit party maintained a strong newspaper link that bordered on censorship. Under Manning, the Social Credit regime bordered on fascist according to some accounts (Finkel, 1989: 87). In other words, the longevity of the government, and the likelihood of the *Sexual Sterilization Act* NOT being repealed during this time become clearer when we realize how stagnant and closed to criticism was the Social Credit government.

But we cannot point only to the Social Credit government for the longevity of the actions of the Eugenic Board of Alberta. The Social Credit government worked in partnership with "experts" and we saw above that experts played a very critical role in the implementation of the *Sexual Sterilization Act*. It is to an analysis of the role of these professionals in the long lifespan of the Act that we now turn.

The government initially gave the experts power to do as they saw fit, according to the legislation, with feebleminded persons in Alberta. However, as we saw above, the mental health and medical professionals involved pushed for more control over the feebleminded and for more control over the interpretation of the Act. Several factors likely contributed to the professionals' thirst for more and more power during this time. The mental health, social work, and medical professions were newly emerging on the scene. These fledgling professions had as perhaps their first and foremost goal, the creation of a niche, a long term stable niche, for themselves. The job of any good profession is to make their services necessary, and necessary to a large group of people. This the professions in question were striving to do. With the passage of the Act and the Amendments they were a much-needed group in Alberta society. Repealing the Act, particularly at this early stage in their development, might have effectively set them back considerably in their goal of establishing themselves as a necessary element in society. For professions, the goal is to " constitute and control a market for their expertise" (Ritzer and Walczak, 1986: 81). In a province 'overrun' with feebleminded persons, such a market would have been ensured.

Part of the power of a profession rests in the uncertainty of the problem they are required to deal with. They can use this uncertainty to make the rest of the world believe they are the only ones who can complete the task at hand. This is compounded by the autonomy we give the professions, and the fact that they are self-regulating. "The profession's monopoly is its ultimate control of the content of its work" (Freidson, 1972: 205). The autonomy and self-regulation also contributed to a situation where the group becomes self-sufficient. The profession "creates a structure of relatively segregated small circles of practitioners, some of which are so isolated from others that the conditions necessary for influencing behaviour across the various circles are missing" (199). Combine this isolation with the desire to expand one's jurisdiction and power within an environment where the government does not question the authority of experts in general, and you have a recipe for a forty-four year long enactment of a *Sexual Sterilization Act*. As Freidson also states, professional autonomy is always limited by some degree by the political power which it needs to create and protect it (1972: 369). In the case of Alberta during this time period, I would argue that such limitations were virtually absent.

This type of situation also "encourages the profession to see itself as the sole possessor of knowledge and virtue, to be somewhat suspicious of the technical and moral capacity of other occupations, and to be at best patronizing and at worst contemptuous of its clientele" (370). We saw evidence of this in the Minutes of the Eugenics Board, particularly in the dealings of le Vann with parents of patients. The problem is that the profession cannot see itself with clear eyes, nor can it clearly see the status or needs of its clients. The end result, which may have contributed to the longevity of the Eugenics Board in Alberta, is that

> they are well-meaning groups, protected from the public and also from their own honest self-scrutiny by their sanctimonious myths of the inherently superior qualities of themselves as professionals – of their knowledge and of their work (Freidson, 1972: 370).

Freidson warns of exactly what I believe happened in Alberta:

> There is a real danger of a new tyranny which sincerely expresses itself in the language of humanitarianism and which imposes its own values on others for what it sees to be their own good (381).

The terms "disinterested expert" or "professional", given the right circumstances, can serve as a "cachet to privilege and authority" (379). Backed by the support of a government that places its trust in the expert class, the end result could be the continuation of a system that, according to scientific standards as well as moral standards of the time, is outdated, dangerous, and unethical.

I have analyzed some of the political, economic and professional characteristics of the province that may have contributed to the enactment of the Act as well as its long-term status. I cannot definitively answer the questions I set out to answer initially, but I think I have come somewhat closer to an understanding of the factors that may have contributed to the situation. In explaining why this happened in Alberta and nowhere else in Canada, it might just be that in Alberta there came together a set of unique circumstances that together created a ripe environment for a sterilization program. We saw that the political climate was certainly very different from that of Saskatchewan despite the fact that immigration, economic, and occupational issues should have made the two provinces similar.

Does the difference also reflect the difference in claimsmakers in each province? How much power did Emily Murphy really exert in her drive to promote sterilization? Did the UFWA have a bigger influence on its parent organization than did political affiliates of the Saskatchewan government? Does the difference have something to do with the close connection between politicians and the medical profession in Alberta? An "intermingling" of power between two powerful and affiliated groups? Dr. W. W. Cross was the Minister of Health during the formative years of the Eugenics Board. Should this enter into an explanation of 'why' and 'why so long'? Likely it should. Perhaps there was something unique about the mental health professionals in Alberta as compared to other provinces? Perhaps given the Act and the freedom it allowed them, the professionals took it upon themselves to pursue a type of 'empire-building'. We saw above that they published articles in academic journals and were doing their own research on some of the patients. Obviously these were men and women who were building their own professional careers at the same time as they were helping the province.

Does the difference also involve differences in leaders who rose to the fore in each province? Aberhart was appealing to former UFA members. In addition he was charismatic, articulate, a professional himself (high school principal), and reached many Albertans through his radio show. We saw above that the UFA never gained much popularity in Saskatchewan. Social Credit attempted to run in a provincial election there and only won two seats (Finkel, 1989). It appears that the political climate was just different in Saskatchewan. Farmers and labour always remained actively involved in provincial politics in Saskatchewan. The province worked toward reform and was plagued during the Depression and afterward with debt to a greater extent than Alberta (Alberta experienced more debt prior to the Depression). One of the primary Saskatchewan leaders, Tommy Douglas, was committed to social democratic ideals; "he ensured the emergence of an attitude to governance different from that of the wealthier sister province" (212). On the other hand, Social Credit in Alberta became authoritarian, dictatorial and reactionary; opposition was suppressed. In addition, the oil industry contributed to political apathy on the part of the public. No one was interested in radical changes to the way things had always operated.

Finally, we saw the importance of experts or "the professions". Granted we can assume that such professions developed in other provinces as well. However, in Alberta the professions were welcomed into an already established mental health system that allowed for sexual sterilization. Given the reign to amend and work within such a system, and given the power allowed such professions because of government reliance on experts, again, we have a unique Alberta situation arising. Perhaps the situation was conducive to the intermingling of a combination of fear (on the part of the public and the government), charismatic politicians, and a public who trusted its leaders (preacher) and professionals (who had to know what was best). Perhaps in a province that believed 'funny money' was the answer to economic problems, the eugenics solution to social problems also seemed reasonable.

Comparisons with Saskatchewan, although valuable, certainly do not provide an answer to the question of why not elsewhere in Canada. Why not Ontario? This is more difficult to answer. It may be that in Ontario there were more powerful groups who were opposed to eugenics. It appears that Catholic interest groups, opposed to birth control of any kind, waged a significant battle against eugenics in the east. The Catholic population may also have been larger in Saskatchewan. It may also be that within the large metropolitan centres in the East, much larger than those in the West, there was a larger professional base and a more educated population. This likely would contribute to more controversy over eugenics theory itself. Out in the distant West, there were a few experts in the field and they dominated. In Freidson's terms, the professionals in the West may have been more isolated, segregated and autonomous than those in the East. This would have allowed them more freedom and independence from both internal and external watchdogs.

This study was described earlier as being a case study that explores the construction of this particular "social problem" in this particular province, during this particular period in history. However, despite all the "particularity" of the study, there are some generalizations that can be made about the construction of social problems and the implications of such constructions.

As with other research on the construction of social problems and the medicalization of deviance, we too discovered that the construction process began with the claimsmaking activities of groups of people. We also discovered that it was primarily elite groups who could use their education and status to influence public perception. We found that relatively disadvantaged groups were targeted by these claimsmaking activities, and the 'scientific' nature of the argument seemed to make the medical solution of sterilization appealing for practical and even "humanitarian" reasons. So we essentially confirmed the research literature by providing yet another example of how powerful people can use science and medicine to construct "deviants" as being problematic populations who need to be controlled.

In addition, we saw how the techniques used by claimsmakers contributed to the 'validity' of their claims. We witnessed the power of the media and the written word in the creation of a social problem. In other words we saw what began as initial concerns over genetics turn into a moral panic which evoked a legislative response. Very quickly, prejudice and frustration with immigrants, criminals, and the feebleminded turned into an outright witchhunt grounded in scientific rhetoric.

In addition to understanding how this "social problem" was created, we also gained a better understanding of the "process" through which people become defined as problematic and through which a solution to the problem is created. We also gained some insight into how it was that the "process" continued for as long as it did. In analyzing the processes occurring in Alberta during this time and by understanding the interplay of the forces at work, we are one step closer to understanding how a similar situation could be prevented from happening again. It may be that if certain other events had occurred in one of the stages in this process, they could have prevented the extent of injustice done. Perhaps if the claimsmakers had not been as convincing or as articulate, perhaps if the governing party had been of a different political persuasion, things could have been different in Alberta. As we saw above, the role of mental health and medical professionals was key to the longevity of the sterilization program in Alberta. Knowing this might make us more aware of similar situations that exist presently or may come into existence in the future.

Our understanding of the social construction of the "process" is as important as understanding the construction of the "problem". The Eugenics Board, a four member, highly educated, high status group, was given next to free reign to 'govern' its own 'domain' for over forty years. The mental health institutions were assigned a role in this process and carried it out dutifully the entire time. The government throughout was complacent in stepping back and permitting things to proceed as they had for years before. So was the public. Each played a role in constructing the process as a necessary, effective, and "humanitarian" feature of Alberta's mental health care system.

Theory and Method

As we mentioned in Chapter Three the purpose of inquiry for social constructivists is ***understanding and reconstruction*** of the constructions that people initially hold (Guba and Lincoln, 1994: 113). The goal is to discover the ways in which knowledge and truth are created and the processes through which this occurs. That has been the primary objective of the present study – to discover the processes through which certain segments of society were constructed as being a social problem. Using the meeting Minutes of the Eugenics Board, the family and sexual history write-ups from the presentation summaries, and the historical context as provided from secondary sources, the study has reconstructed many aspects of eugenics in Alberta.

As such this research is very grounded in the data. It was necessary to immerse oneself in the data, in the Minutes and presentation summaries, in order for that story to emerge and for the reconstruction to occur. Social constructionism does not 'prescribe' one particular method for conducting research. The goal is to use whatever means are appropriate to the data and to telling the story. As such the present study used a variety of methods, ranging from crosstab analysis to discourse analysis. Telling "the story" necessitated using a variety of methods.

Would other researchers using the same or different methods discover a similar story? Is there an 'objective reality' that is being described, or is the story-telling process so subjective that this is simply one of many (different) perspectives on the eugenics movement in Alberta? In the earlier discussion of the social constructionist perspective, one of the criticisms directed at the perspective was the question regarding which of the accounts of an event is the "right" account. If all constructions are equally valid, how is any account "better" than the others?

In response, some members of the social constructionist camp allow for or admit subtle realism (Schwandt, 1994: 130). The social constructionist approach does not have to be anti-realist. For such theorists, admitting that there is something 'out there', something underlying and infuencing the event, does not detract from the validity or value of the approach. It is this stance that I take in drawing some conclusions about this case study.

The 'reality' is that 2834 people were sterilized. There was a Eugenics Board in Alberta, created as a result of a *Sexual Sterilization Act*. Sixty four percent of women presented were sterilized. Fifty-four percent of men presented were sterilized. In the 1950s and 1960s more children and teenagers were sterilized. Throughout the years of operation of the Eugenics Board, Aboriginal patients stood a greater chance of being sterilized. If any other researcher were to go through the Minutes and files they would reach the same conclusions, because this is the reality, these are the facts. In addition, I believe that if any other researcher read the Minutes and the case files, he or she would come to some very similar conclusions. In fact, the studies already conducted on this topic reached similar conclusions. Christian (1974), Park and Radford (1998), even the academic articles produced by members of the eugenics movement[3], all essentially said the same things. Granted, the latter were promoting eugenics, and the former were reconstructing the story from a very different perspective. But each confirms what has been said in the pages of my "story".

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[3] C.A. Baragar, Geo. A. Davidson, W. J. McAlister, and D. L. McCullough. 1935. "Sexual Sterilization: Four Years Experience in Alberta". *American Journal of Psychology.* 91 (2): 897 – 923; E. Mary Frost. 1942. "Sterilization in Alberta: A Summary of the Cases Presented to the Eugenics Board for the Province of Alberta from 1929 to 1941". Master's Thesis. University of Alberta; R.R. MacLean and E. J. Kibblewhite. 1937. "Sexual Sterilization in Alberta: Eight Years' Experience, 1929 to May 31, 1937". *Canadian Public Health Journal.* 587-590.

The present study offers a more comprehensive reconstruction than the other studies partly because of the greater amount and variety of data available. The reconstruction has occurred at the societal level, the Board level, and the institutional level. However, this study has also benefited from the previous studies, and because it is more self-consciously aware of its social constructionist stance, it can incorporate the previous findings in building this reconstruction.

The value lies in this 'consensus-building' that occurs as a result of multiple confirming or similar constructions. "'Objectivity'…is not innate to any state or condition of the world, but reflects the intersubjective consensus attained within particular contexts…" (Prus, 1996: 88). This occurs at the community level as people create reality, but also at the level of reconstructions. "Objectivity" regarding the story of eugenics occurs when repeated constructions are created which confirm and reconfirm what previous stories have said. For this reason, I believe that a future reconstruction of the eugenics story will reconfirm what this study and those before it have said.

The implication for social constructionism as a theoretical approach is that it may be best to admit subtle realism. For particular social problems it may be appropriate to take social constructionism to its logical conclusion, which is to deny any truly objective conditions that influence the shaping of events. In such instances, the deconstruction might occur to the point where all semblance of 'reality' is denied. But for a social problem such as the one discussed here, deconstructionism to such a logical conclusion is illogical. Some social constructionists reject a Foucauldian approach as being too deconstructionist. This is the stance taken here as well. Could one deconstruct the events of the eugenics movement in Alberta to the point where the sterilization of over 2800 people would become a relatively moot point? Not likely. There is a reality for those people, and that reality precludes having children, and for some, having their childhoods restored to them. A theoretical approach that addresses a social problem such as this one must recognize the existence of objective conditions, conditions that many researchers acknowledge through their own reconstructions and that ultimately influence the outcome of the construction process. Admitting subtle realism, however, is not the same as arguing for a completely objective empirical reality.

Finally, the constructivist approach allows for the writer as constructor to incorporate values of altruism, empowerment and advocacy into the story-telling process. The inquirer's voice is that of the "passionate participant" (Guba and Lincoln, 1994: 131). The author in this case and from this perspective is permitted some degree of power to give the patients of the Eugenics Board more agency than they were allowed previously. In telling their story, and the story of the Eugenics Board, the constructor can give a voice to voices that historically have been silenced.

Current and Future Implications

> "Eugenic goals are most likely to be attained under a name other than eugenics"
> (Frederick Osborn, 1968 from Paul, 1995: 132)

> "When eugenics reincarnates this time, it will not come through the front door, as with Hitler's *Lebensborn* project. Instead, it will come by the back door of screens, treatments, and therapies" (Duster 1990, in Paul, 1995: 133).

> "The Human Genome Project is both science and metaphor. It will create a track in dense social vapor. It will confront us with our own assumptions about what it is to be human, to be ill, to be perfect, to be monster, and to be wise. The Human Genome Project is culture-saturated science." (Howard Stein, 1992 from Hasian, 1996: 139).

This "process" that we speak of, and the construction of the "process" is an issue that did not die with the *Sexual Sterilization Act* in 1972. The "process" of socially constructing social problems is a current issue. For this reason the present study has implications for the present and the future. Eugenics principles take different forms today. Euthanasia is an issue we have been grappling with for years. We read and hear about cloning, designer babies, testing fetuses and adults for diseases based on genetics, and identifying genes responsible for particular conditions and behaviour. As a society we are concerned about our future survival and the 'quality' of future generations. All are linked back to the issues raised by Plato, by Galton, and yes, by Hitler too. Have we really left these contentious ideas and actions behind us? No. We have not. We witness the same eugenics issues resurface, but this time, they resurface under a new guise. To understand the implications of these present concerns requires an understanding of the issues discussed in the previous pages of this study. Eugenics is going through "a scientific reconstruction" (Hasian, 1996: 140).

The same arguments are resurfacing, albeit in a somewhat different form, as are the same issues that we have just discussed in the context of the Eugenics movement in Alberta in the early 20th century. In addition, similar claimsmaking tactics are being used. There is a concern for the future of the human race; individuals are exhorted to be responsible in their parenting choices in order to contribute to the survival of nations (Hasian, 1996: 147). The first director of the Human Genome Project, a multi-billion program aimed at mapping and sequencing the genes that control our heredity, argues in his articles and speeches that genetics are the predominant factor in human development. In his speeches and articles he discusses the importance for individuals and families to "use genetics in order to decide issues such as whom to marry or what genes should be removed from the gene pool…in the same speech we are told that any prospective child carrying certain genes would be born without any opportunity for a meaningful life" (Hasian, 1996: 147). Is this not the "mental injury to progeny" argument revisited? In addition, we are seeing a renewal in use of the "pedigree charts"[4] of the 1910s, 1920s, and 1930s (1996: 146).

Also revisited is the link between certain behaviours and race, as well as the focus on women's responsibility for making the "right" choices regarding reproduction (Hasian, 1996). As well, financial concerns at the individual and societal level are integral to these discussions. These discussions are rife with references to class issues and class control. In discussing the Genome Project and its ultimate goals "many normative judgments have been made on the reproductive habits of the underclass" (Hasian, 1996: 151). As with some of the arguments for sterilization we saw earlier in Alberta society, government concern with costs of health care is also apparent in present day discussions:

> Human mating that proceeds without the use of genetic data

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[4] "Pedigree charts" were used in "family studies" to document the incidence within rural clans of social ill such as pauperism, prostitution, insanity, and crime. Such pedigrees illustrated the recurrence of undesirable traits in several generations of the same family. It could then be assumed, if the trait ran in families, that it was an inherited trait. (Diane B. Paul, 1995. *Controlling Human Heredity: 1865 to the Present*. p. 42)

> about the risks of transmitting diseases will produce greater mortality and medical costs than if carriers of potentially deleterious genes are alerted to their status and encouraged to mate with noncarriers or to use artificial insemination or other reproductive strategies (Hasian, 1996: 151).

As was mentioned earlier, the reconstruction of this process does differ; we have learned some things from our past. Present day proponents of genetic engineering technologies argue that what they are doing is NOT eugenics. For them eugenics is linked to government or state control. Rather what we are faced with now is what they term "medical genetics" (Paul, 1995: 133). If it is not associated with the state, it is not eugenics.

Rather, the emphasis with "medical genetics" is on *individual autonomy and choice*. It is up to *individuals* to decide if they want genetic testing for themselves or their fetuses before carrying through with the pregnancy. The social pressures on parents to abort "genetically defective" fetuses is often left out of these discussions. From this perspective, "all persons have the right of "choice", but it is important that they make the *right* choice" (Hasian, 1996: 147). As Hasian points out, "enormous social pressure obviates the need for government coercion" (1996: 152). With this emphasis on individual choice, we may be in a position to achieve the same eugenics goals advocated by earlier generations, but through medical technology as opposed to state control, the former being much more palatable in this age of individualism and independence. The end result could be the same as eugenics the first time around, since many of these genetic technologies will be primarily available to people educated enough to be aware of them, and wealthy enough to afford them. In other words, the people controlling the technology will be of the same type as the elite who promoted eugenics ideals in the past. Confidence in an 'educated' public means that "instead of basing their decisions on speculative fears and anxieties, laypersons are supposed to use 'therapeutic' frames of reference" (Hasian, 1996: 147). As Paul warns though, "acts are not benign simply because their agents are private citizens" (1995: 135).

However, private citizens are not the only actors in this new eugenics play. As in the historical case of Alberta, we witness the importance to eugenics of the professional class: scientists, medical professionals, and now 'genetics counsellors'. No longer do we need a Eugenics Board to order sterilization operations. Rather, because the need for such a program speaks for itself among an educated public, the new profession that rises to the occasion is comprised of researchers and promoters of the idea, as well as the 'helpers' who make options and choices clear to autonomous 'consumers'. There is no government regulation or coercion with the new eugenics because geneticists have learned from the past. The Human Genome Project has within it a special task force whose responsibility is the monitoring of ethical, legal and social implications of this type of research (Hasian, 1996: 146). The rhetoric surrounding present day genetic research is such that we are made aware of professional refusal to "cede control of genetic discoveries to those who would misuse them" (145).

> The defenders of the Human Genome Project thus attempt to gain the rhetorical high ground by acknowledging the potential dangers of the program while at the same time denying any links between their research agendas and the prejudices, politics, and vagaries of the time (145).

The implication is that modern researchers are more able than those of the past to maintain objectivity and healthy skepticism. Once again we are led to believe that genetic and medical professionals will always act responsibly and in a humanitarian manner, that they know what is best for us. As we saw above, historical evidence shows us otherwise. It appears that we are falling into the same trap that was set for us in our not-so-distant past. As Rothman writes, "Genetics tells us we can make a better world by engineering better people. Sociology tells us we must first make the world safe for genetics" (1998: 504).

The role of professionals in the past, present and future 'eugenics' policies and practices is a recurring theme. Our trust in professionals and our granting of self-regulation and status to them and their work make us vulnerable. The theme of the 'expert' knowing what is best for the nonexpert continues to characterize the eugenics issue, but also many others. We allow professionals to construct many "social problems"; we as academics and researchers are party to similarly powerful constructions. We speak of "children at risk", of "dangerous offenders", and in so doing we create an insider/outside distinction that allows us to "predict" future behaviour of groups of people, to prescribe treatment, to remove freedoms. My goal is certainly not to construct yet another "social problem" - that of experts – nor is it to create a moral panic about professionals. My goal is to point out this rather persistent theme. Whatever the social problem, whatever the period in history, the social construction process appears to be similar. The implication is similar too: if we invest power and knowledge into particular groups and if we grant them the power to define what is to be designated as a "social problem", how do we ensure that certain other groups are not excluded on the bases of socially-ascribed characteristics? How do we ensure that, as with the eugenics movement in Alberta in the first half of the 20th century, thousands of people are not robbed of basic human rights just because they were 'different', in ways that were deemed morally 'wrong' by the professional class? We speak of experts as those who are to watch over society, to use their knowledge to protect the interests of society. This leads to the age-old question - who will watch over the experts and protect society from them?

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1928

CHAPTER 37.

The Sexual Sterilization Act.

(Assented to March 21, 1928)

HIS MAJESTY, by and with the advice and consent of the Legislative Assembly of the Province of Alberta, enacts as follows:

1. This Act may be cited as "The Sexual Sterilization Act."

2. In this Act, unless the context otherwise requires --

(a) "Mental Hospital" shall mean a hospital within the meaning of The Mental Diseases Act;

(b) "Minister" shall mean the Minister of Health.

3. (1) For the purpose of this Act, a Board is hereby created, which shall consist of the following four persons:

Dr. E. Pope, Edmonton
Dr. E. G. Mason, Calgary.
Dr. J. M. McEachran, Edmonton.
Mrs. Jean H. Field, Kinuso.

(2) The successors of the said members of the Board shall from time to time, be appointed by the Lieutenant Governor in Council, but two of the said Board shall be medical practitioners nominated by the Senate of the University of Alberta and the Council of the College of Physicians respectively, and two shall be persons other than medical practitioners, appointed by the Lieutenant Governor in Council.

4. When it is proposed to discharge any inmate of a mental hospital, the Medical Superintendent or other officer in charge thereof may cause such inmate to be examined by or in the presence of the board of examiners.

5. If upon such examination, the board is unanimously of opinion that the patient might safely be discharged if the danger of procreation with its attendant risk of multiplication of the evil by transmission of the disability to progeny were eliminated, the board may direct in writing such surgical operation for sexual sterilization of the inmate as may be specified in the written direction and shall appoint some competent surgeon to perform the operation.

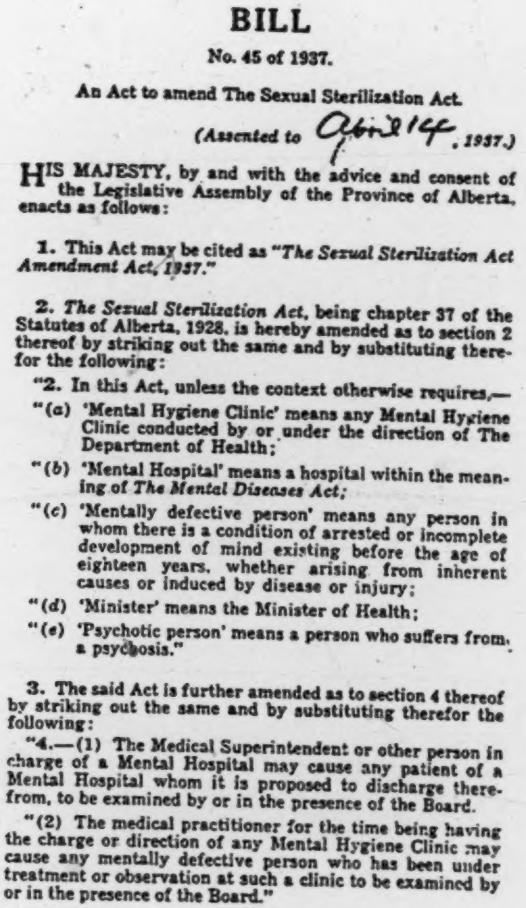
6. Such operation shall not be performed unless the inmate, if in the opinion of the board, he is capable of giving consent, has consented thereto, or where the board is of opinion that the inmate is not capable of giving such consent, the husband or wife of the inmate or the parent

or guardian of the inmate if he is unmarried has consented thereto, or where the inmate has no husband, wife, parent or guardian resident in the Province, the Minister has consented thereto.

7. No surgeon duly directed to perform any such operation shall be liable to any civil action whatsoever by reason of the performance thereof.

8. This Act shall have effect only insofar as the legislative authority of the Province extends.

Appendix 2: Amendment to the Act



BILL

No. 45 of 1937.

An Act to amend The Sexual Sterilization Act.

(Assented to April 14, *1937.)*

HIS MAJESTY, by and with the advice and consent of the Legislative Assembly of the Province of Alberta, enacts as follows:

1. This Act may be cited as "*The Sexual Sterilization Act Amendment Act, 1937.*"

2. *The Sexual Sterilization Act*, being chapter 37 of the Statutes of Alberta, 1928, is hereby amended as to section 2 thereof by striking out the same and by substituting therefor the following:

"2. In this Act, unless the context otherwise requires,—

"(*a*) 'Mental Hygiene Clinic' means any Mental Hygiene Clinic conducted by or under the direction of The Department of Health;

"(*b*) 'Mental Hospital' means a hospital within the meaning of *The Mental Diseases Act;*

"(*c*) 'Mentally defective person' means any person in whom there is a condition of arrested or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury;

"(*d*) 'Minister' means the Minister of Health;

"(*e*) 'Psychotic person' means a person who suffers from a psychosis."

3. The said Act is further amended as to section 4 thereof by striking out the same and by substituting therefor the following:

"4.—(1) The Medical Superintendent or other person in charge of a Mental Hospital may cause any patient of a Mental Hospital whom it is proposed to discharge therefrom, to be examined by or in the presence of the Board.

"(2) The medical practitioner for the time being having the charge or direction of any Mental Hygiene Clinic may cause any mentally defective person who has been under treatment or observation at such a clinic to be examined by or in the presence of the Board."

4. The said Act is further amended as to section 5 thereof by striking out the same and by substituting therefor the following:

"5.—(1) If upon examination of a psychotic person the Board is unanimously of the opinion that the exercise of the power of procreation would result in the transmission to such person's progeny of any mental disease, or that the exercise of the power of procreation by any such psychotic person involves the risk of mental injury, either to such person or to his progeny, the Board may direct in writing, such surgical operation for the sexual sterilization of such psychotic person as may be specified in the written direction, and shall appoint some competent surgeon to perform the operation.

"(2) In the case of a psychotic person, such operation shall not be performed unless such person being in the opinion of the Board a person who is capable of giving consent, has consented thereto, or when the Board is of the opinion that such person is not capable of giving such consent, if such person has a husband or wife, or being unmarried has a parent or guardian, resident within the Province, the husband, wife, parent or guardian of such person has consented thereto."

5. The said Act is further amended as to section 6 thereof by striking out the same and by substituting therefor the following:

"6. If, upon examination of any mentally defective person, the Board is unanimously of the opinion that the exercise of the power of procreation would result in the transmission to such person's progeny of any mental disability or deficiency, or that the exercise of the power of procreation by any such mentally defective person involves the risk of mental injury either to such person or to his progeny, the Board may direct, in writing, such surgical operation for the sexual sterilization of such mentally defective person as may be specified in the written direction and shall appoint some competent surgeon to perform the operation."

6. The said Act is further amended as to section 7 by striking out the same and by substituting therefor the following:

"7. No person shall be liable in any civil action or proceeding for any thing done by him in good faith in purported pursuance of this Act, if that person is,—

"(*a*) ~~a surgeon directed to perform any operation for sexual sterilization pursuant to this Act~~;

"(*b*) a person who consents to the performance of any such operation;

"(*c*) the Medical Superintendent or officer in charge of any Mental Hospital who causes any patient to be examined pursuant to this Act;

"(*d*) the medical practitioner having the charge or direction of a Mental Hygiene Clinic who causes any person to be examined pursuant to this Act;

"(*e*) a member of the Board."

7. This Act shall come into force on the day upon which it is assented to.

AMENDMENT TO BILL No. 45 of 1937.

Amend section 6 of the Bill by striking out paragraph (a) of section 7 and by substituting therefor the following:

X "(a) a surgeon directed to perform any operation for sexsual sterilization pursuant to this Act, and any person who, in connection with any such operation, acts as an anaesthesist or takes any part therein or assists such surgeon in the performance thereof;"

Appendix 3: Bill 26

1998 BILL 26

Second Session, 24th Legislature, 47 Elizabeth II

THE LEGISLATIVE ASSEMBLY OF ALBERTA

BILL 26

INSTITUTIONAL CONFINEMENT AND SEXUAL STERILIZATION COMPENSATION ACT

THE MINISTER OF JUSTICE AND ATTORNEY GENERAL

First Reading ....

Second Reading ....

Committee of the Whole ....

Third Reading ....

Royal Assent ....

BILL 26

1998

INSTITUTIONAL CONFINEMENT AND SEXUAL STERILIZATION COMPENSATION ACT

(Assented to , 1998)

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Application 2
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Limitation periods, defences 4
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Interest 6
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Costs 8

Schedules

Preamble

WHEREAS certain persons were resident in institutions in Alberta pursuant or purportedly pursuant to one or more Acts listed in Schedule 2; and

WHEREAS from 1927 to 1972 certain medical procedures were performed on persons in Alberta pursuant to or allegedly pursuant to a *Sexual Sterilization Act* listed in Schedule 2; and

WHEREAS persons have brought and may bring claims against Her Majesty the Queen in right of Alberta in respect of alleged confinement in those institutions and in respect of the performance of those medical procedures; and

WHEREAS the Government of Alberta desires to balance the interests of the persons bringing the claims and the interests of all Albertans by removing certain impediments to compensation and by implementing compensation principles to assist in resolving the claims in a fair and consistent manner;

THEREFORE HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Alberta, enacts as follows:

ions

1 In this Act,

(a) "action" means an action against Her Majesty the Queen in right of Alberta in which the plaintiff claims any or all of the following, regardless of the nature of the cause of action and regardless of whether the plaintiff also claims damages in relation to other matters:

(i) damages in relation to a procedure listed in Schedule 1 that was authorized, directed or performed on the plaintiff pursuant to or purportedly pursuant to a *Sexual Sterilization Act* listed in Schedule 2;

(ii) damages arising out of the confinement of the plaintiff pursuant to or purportedly pursuant to an Act listed in Schedule 2, including damages, if any, in relation to any of the following matters, except damages for sexual assault committed against the plaintiff:

(A) the care, supervision of care or custody of the plaintiff;

(B) the plaintiff's education;

(C) the administration of drugs or medication to the plaintiff;

(D) a tort committed against the plaintiff;

(E) any duty or obligation owed to the plaintiff;

(iii) damages for sexual assault committed against the plaintiff during the confinement of the plaintiff pursuant to or purportedly pursuant to an Act listed in Schedule 2;

(b) "Her Majesty the Queen in right of Alberta" includes an employee or agent of, or a person under a contract or fee for service arrangement with, Her Majesty the Queen in right of Alberta;

(c) "plaintiff" means the person who is alleged to have suffered loss, regardless of whether the action is brought in the person's own name or in the name of another on that person's behalf;

(d) "sexual assault" means an assault in the form of fellatio, cunnilingus, vaginal or anal intercourse or digital penetration.

Application

2 This Act applies to all actions, whether commenced before or after the coming into force of this Act, except actions in which final judgment was given before the coming into force of this Act.

Override of Charter

3 This Act operates notwithstanding

(a) the provisions of sections 2 and 7 to 15 of the *Canadian Charter of Rights and Freedoms*, Part 1, *Constitution Act, 1982*, Schedule B to the *Canada Act, 1982*, (U.K.) 1982 c11, and

(b) the *Alberta Bill of Rights*.

Limitation periods, defences

4(1) A law that would, but for this section, prohibit the bringing of an action claiming damages referred to in section 1(a)(i), (ii) or (iii) by reason of the passage of time does not operate to prohibit the action if the action

(a) was commenced before the coming into force of this Act, or

(b) is commenced within 180 days after the coming into force of this Act.

(2) Notwithstanding any other law in force in Alberta, no action may be commenced after the 180-day period referred to in subsection (1)(b).

(3) Where, in the case of a claim for damages referred to in section 1(a)(iii), the individual defendant who is alleged to have committed the sexual assault would, but for subsection (1), have been able to successfully defend the claim, the court shall not make any of the following awards as against the individual defendant:

(a) an award of damages referred to in section 1(a)(iii) that is in excess of $150 000;

(b) an award in respect of non-compensatory, punitive, exemplary or aggravated damages under section 5(3);

(c) an award for pre-judgment interest under section 6(2).

(4) Subject to subsection (2) no defence against liability in respect of a claim referred to in section 1(a)(i) is available to Her Majesty the Queen in right of Alberta in an action.

5(1) Where a court awards damages to a plaintiff in one or more actions,

(a) the aggregate amount that is awarded for damages referred to in section 1(a)(i) must not be less than $5000,

(b) the aggregate amount that is awarded for all damages referred to in section 1(a)(i) and (ii) must not exceed $150 000, and

(c) the aggregate amount that is awarded for damages referred to in section 1(a)(iii) as against all defendants other than the individual defendant who is found by the court to have committed the sexual assault must not exceed $150 000.

(2) Subject to subsection (3), a court shall not make any award in respect of non-compensatory, punitive, exemplary or aggravated damages in an action.

(3) In the case of a claim for damages referred to in section 1(a)(iii) a court may make an award referred to in subsection (2) in respect of the sexual assault but only as against the individual defendant who is found by the court to have committed the sexual assault.

6(1) Notwithstanding the *Judgment Interest Act* but subject to subsection (2), a court shall not make an award for pre-judgment interest in an action.

(2) Where a court awards damages referred to in section 1(a)(iii), the court may make an award for pre-judgment interest only as against the individual defendant who is found by the court to have committed the sexual assault.

ution
arious

7 Notwithstanding the *Contributory Negligence Act*, any law in respect of vicarious liability or any other law in force in Alberta, the other defendants in an action are not liable for the payment of

(a) that part of an award of damages referred to in section 1(a)(iii) as against the individual defendant who is found by the court to have committed the sexual assault, that is in excess of $150 000, or

(b) any part of an award for non-compensatory, punitive, exemplary or aggravated damages or for pre-judgment interest made against the individual defendant referred to in clause (a).

Costs

8(1) A court shall not award costs on a solicitor and client basis in an action.

(2) Where in an action a court awards costs between parties, those costs must not exceed the amounts set out in the columns of Schedule C of the *Alberta Rules of Court*, depending on the amount involved, and without any multiplier.

SCHEDULE 1

Bilateral Hysterectomy
Bilateral Oophorectomy
Bilateral Orchidectomy
Bilateral Salpingectomy
Bilateral Salpingo-oophorectomy
Bilateral Salpingo-oophorectomy and Hysterectomy
Bilateral Tubal Ligation
Bilateral Vasectomy
Bilateral Vasectomy and Orchidectomy
Hysterectomy
Oophorectomy
Orchidectomy
Salpingectomy
Salpingo-oophorectomy
Testicular Biopsy
Unilateral Orchidectomy
Unilateral Salpingectomy
Unilateral Salpingectomy and Contralateral Salpingectomy
Unilateral Salpingectomy-oorphorectomy and Contralateral Oophorectomy
Unilateral Testicular Biopsy
Unilateral Vasectomy
Unilateral Vasectomy and Contralateral Epididymectomy
Unilateral Vasectomy and Contralateral Orchidectomy
Vasectomy
Any other procedure, however described, that involves the removal or alteration of a sexual reproductive organ or related tissue.

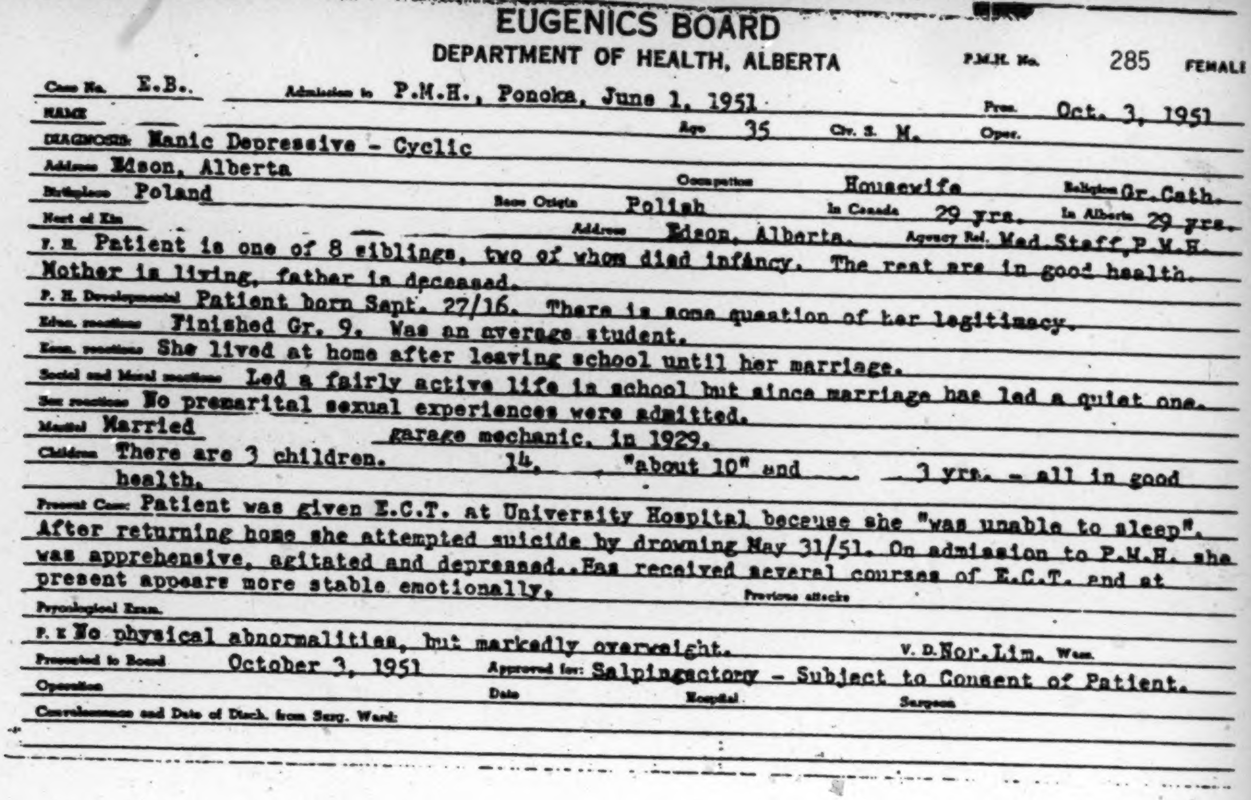
SCHEDULE 2

The Insanity Act, SA 1907 c7
The Insanity Act, RSA 1922 c223
The Mental Defectives Act, RSA 1942 c191

The Mental Defectives Act, RSA 1955 c199
The Mental Diseases Act, RSA 1942 c192
The Mental Diseases Act, RSA 1955 c200
The Mental Health Act, SA 1964 c54
The Mental Health Act, RSA 1970 c231
The Estates of the Mentally Incompetent Act, RSA 1942 c23
The Mentally Incapacitated Persons Act, RSA 1955 c201
The Mentally Incapacitated Persons Act, RSA 1970 c232
The Sexual Sterilization Act, SA 1928 c37
The Sexual Sterilization Act, RSA 1942 c194
The Sexual Sterilization Act, RSA 1955 c311
The Sexual Sterilization Act, RSA 1970 c341

[redacted]

Appendix 4: Sample of a "Case Card Summary"



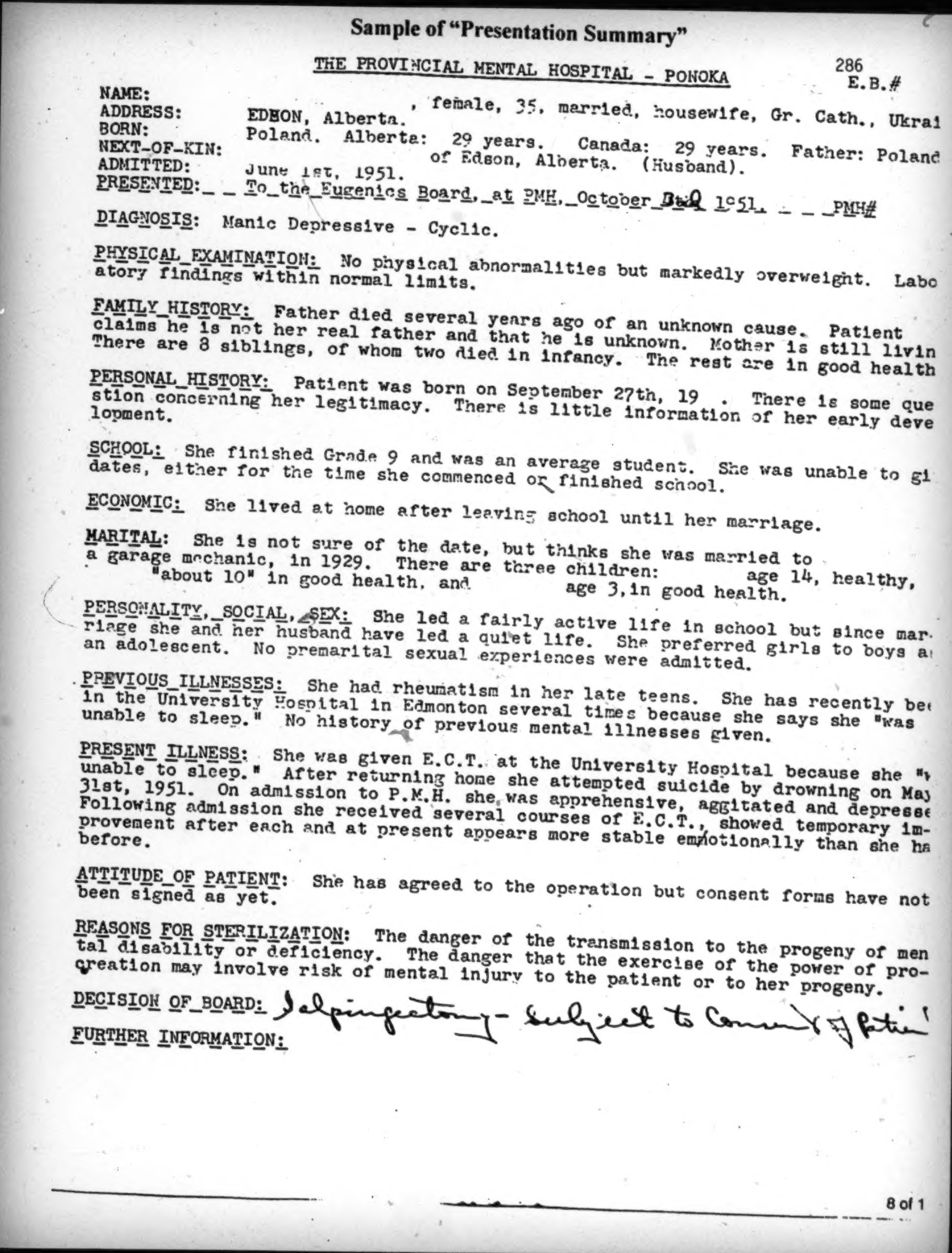
[redacted]

EUGENICS BOARD
DEPARTMENT OF HEALTH, ALBERTA

P.M.H. No. 285 FEMALE

Case No. E.B. Admission to P.M.H., Ponoka, June 1, 1951
NAME Pres. Oct. 3, 1951
Age 35 Civ. S. M. Oper.
DIAGNOSIS Manic Depressive - Cyclic
Address Edson, Alberta
Occupation Housewife Religion Gr. Cath.
Birthplace Poland Race Origin Polish In Canada 29 yrs. In Alberta 29 yrs.
Next of Kin Address Edson, Alberta. Agency Ref. Med. Staff, P.M.H.
F. H. Patient is one of 8 siblings, two of whom died infancy. The rest are in good health. Mother is living, father is deceased.
P. H. Developmental Patient born Sept. 27/16. There is some question of her legitimacy.
Educ. reactions Finished Gr. 9. Was an average student.
Econ. reactions She lived at home after leaving school until her marriage.
Social and Moral reactions Led a fairly active life in school but since marriage has led a quiet one.
Sex reactions No premarital sexual experiences were admitted.
Marital Married garage mechanic, in 1929.
Children There are 3 children. 14, "about 10" and 3 yrs. - all in good health.
Present Case: Patient was given E.C.T. at University Hospital beceuse she "was unable to sleep". After returning home she attempted suicide by drowning May 31/51. On admission to P.M.H. she was apprehensive, agitated and depressed.. Has received several courses of E.C.T. and at present appears more stable emotionally.
Previous attacks
Psychological Exam.
P. E No physical abnormalities, but markedly overweight. V. D. Nor. Lim. Wass.
Presented to Board October 3, 1951 Approved for: Salpingectomy - Subject to Consent of Patient.
Operation Date Hospital Surgeon
Convalescence and Date of Disch. from Surg. Ward:

Sample of "Presentation Summary"



THE PROVINCIAL MENTAL HOSPITAL - PONOKA

286
E.B.#

NAME: , female, 35, married, housewife, Gr. Cath., Ukrai
ADDRESS: EDSON, Alberta.
BORN: Poland. Alberta: 29 years. Canada: 29 years. Father: Poland
NEXT-OF-KIN: of Edson, Alberta. (Husband).
ADMITTED: June 1st, 1951.
PRESENTED: To the Eugenics Board, at PMH, October 3rd 1951. PMH#

DIAGNOSIS: Manic Depressive - Cyclic.

PHYSICAL EXAMINATION: No physical abnormalities but markedly overweight. Labo atory findings within normal limits.

FAMILY HISTORY: Father died several years ago of an unknown cause. Patient claims he is not her real father and that he is unknown. Mother is still livin There are 8 siblings, of whom two died in infancy. The rest are in good health

PERSONAL HISTORY: Patient was born on September 27th, 19 . There is some que stion concerning her legitimacy. There is little information of her early deve lopment.

SCHOOL: She finished Grade 9 and was an average student. She was unable to gi dates, either for the time she commenced or finished school.

ECONOMIC: She lived at home after leaving school until her marriage.

MARITAL: She is not sure of the date, but thinks she was married to a garage mechanic, in 1929. There are three children: age 14, healthy, "about 10" in good health, and age 3, in good health.

PERSONALITY, SOCIAL, SEX: She led a fairly active life in school but since marriage she and her husband have led a quiet life. She preferred girls to boys a an adolescent. No premarital sexual experiences were admitted.

PREVIOUS ILLNESSES: She had rheumatism in her late teens. She has recently be in the University Hospital in Edmonton several times because she says she "was unable to sleep." No history of previous mental illnesses given.

PRESENT ILLNESS: She was given E.C.T. at the University Hospital because she " unable to sleep." After returning home she attempted suicide by drowning on Ma 31st, 1951. On admission to P.M.H. she was apprehensive, aggitated and depress Following admission she received several courses of E.C.T., showed temporary improvement after each and at present appears more stable emotionally than she ha before.

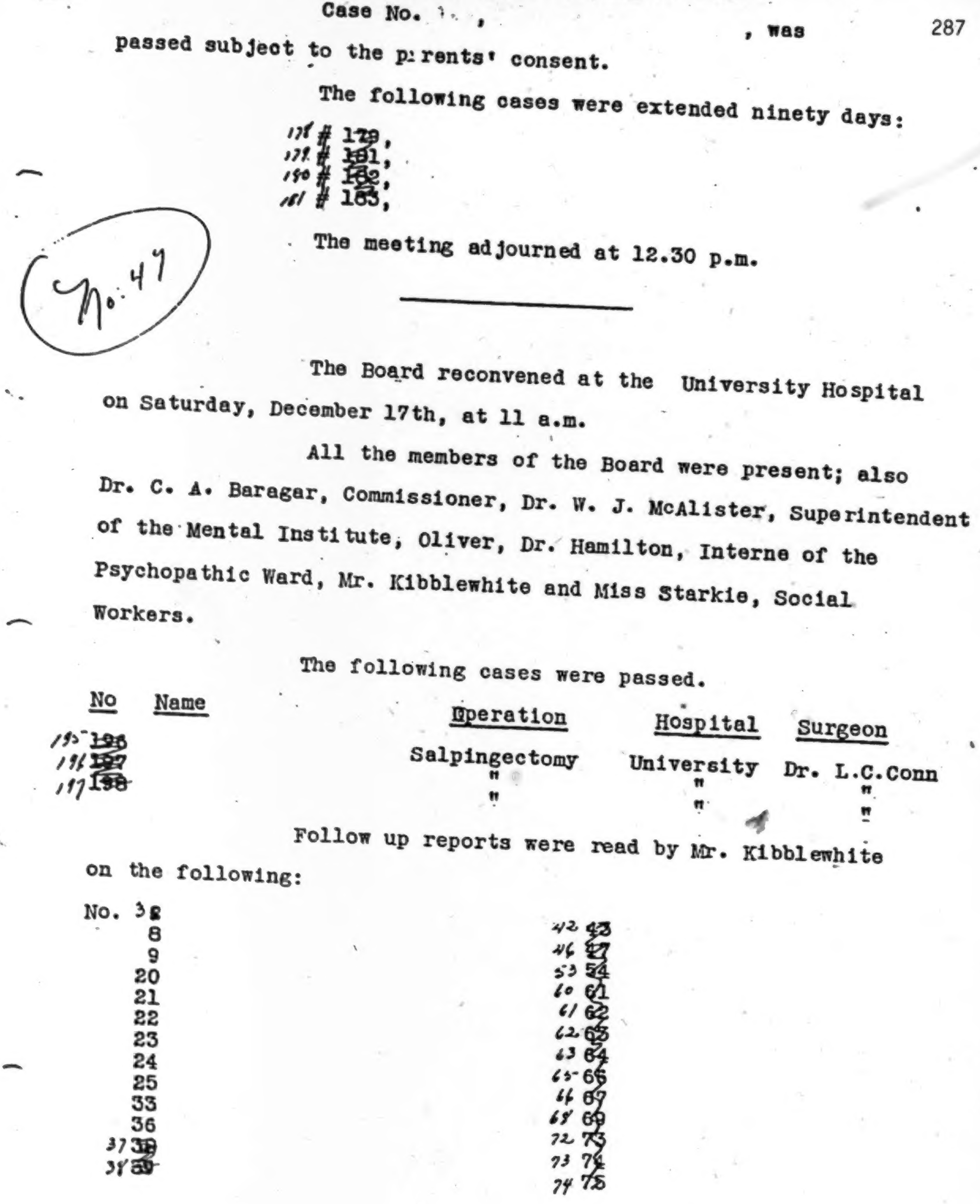
ATTITUDE OF PATIENT: She has agreed to the operation but consent forms have not been signed as yet.

REASONS FOR STERILIZATION: The danger of the transmission to the progeny of men tal disability or deficiency. The danger that the exercise of the power of procreation may involve risk of mental injury to the patient or to her progeny.

DECISION OF BOARD: Salpingectomy - Subject to Consent of Patient

FURTHER INFORMATION:

Appendix 5: Sample of Meeting Minutes



Case No. , , was passed subject to the parents' consent.

The following cases were extended ninety days:

178 # ~~179~~,
179 # ~~181~~,
180 # ~~182~~,
181 # ~~183~~,

The meeting adjourned at 12.30 p.m.

No. 47

The Board reconvened at the University Hospital on Saturday, December 17th, at 11 a.m.

All the members of the Board were present; also Dr. C. A. Baragar, Commissioner, Dr. W. J. McAlister, Superintendent of the Mental Institute, Oliver, Dr. Hamilton, Interne of the Psychopathic Ward, Mr. Kibblewhite and Miss Starkie, Social Workers.

The following cases were passed.

No	Name	Operation	Hospital	Surgeon
195 ~~196~~		Salpingectomy	University	Dr. L.C.Conn
196 ~~197~~		"	"	"
197 ~~198~~		"	"	"

Follow up reports were read by Mr. Kibblewhite on the following:

No. 3 ~~2~~
8
9
20
21
22
23
24
25
33
36
37 ~~38~~
38 ~~39~~

42 ~~43~~
46 ~~47~~
53 ~~54~~
60 ~~61~~
61 ~~62~~
62 ~~63~~
63 ~~64~~
65 ~~66~~
66 ~~67~~
68 ~~69~~
72 ~~73~~
73 ~~74~~
74 ~~75~~

Appendix 6: Sample of "Follow-up Reports"

FOLLOW-up NOTES FOR THE EUGENICS BOARD MEETING ON JANUARY 22, 1942
ON CALGARY CLINIC CASES.

MRS.

E.B. # Operation I0-8-38.

Living in a small apartment with her husband and child who is now four years old. She does not mix well with others and usually takes her little boy out for a walk for recreation. At times she wishes that she had not rushed into marriage as she did. Her married life is not completely happy as she and her husband have little mutual interests. She is quite satisfied with the operation, but complained of a heavier menstrual flow since.

MR.

E.B. # Operation I2-I0-39.

Living with his wife and two children in a small shack on the river bank. Is getting along fairly well but is full of complaints about the economic system. Has had five epileptic attacks in the last eight months. Is against taking any form of medicine to lessen the seriousness of the attacks. The elder child, 4 years, does not talk to any extent and is a chronic thumb-sucker. Family just manage to make ends meet on income totalling $58 a month. Mr. does occasional gardening and earns $I a day. Family also get a small pension. Mr. is very satisfied with the operation.

E.B. # . Operation done in I933.

Parents are very glad that has been operated on. Night emissions continued for about two years after the operation but have now stopped. has gained considerable weight in recent years. He is shy and quiet, spending most of his time at home or with his close relatives. Is still very apprehensive when meeting strangers. Parents have trained him quite well in eating habits, politeness, and so forth, considering his low mentality.

MRS.

E.B. # . Operated on in I934.

is still at home with her mother. She married a soldier, who is now overseas. 's child is very slow in school. She is now nine years old, and is still in the Pre-Primary Class.

E.B. # . Operated on in May I936.

Parents are now running a grocery store. is at home, and it is her responsibility to do the housework for the family who live in quarters at the back of the store. She stopped attending Special Class a year ago at the age of eighteen. She attends C.G.I.T. and goes to church fairly regularly. She does not go out with boys but has a few girl friends. She is fairly attractive in appearance, has been in good health following her operation and seems to be happy in her present circumstqnces.

E.B. # Operated on in August I937.

Is now before the Court on a charge of raping a thirteen year old girl. Considerable community feeling has been aroused over the incident.

E.B. # - Operated on in August 1938.

Is attending Senior Girls' Special Class and likes the work there, especially cooking. Takes quite an interest in caring for her brother's young baby. She can wash dishes, dust, and make beds at home when she is in the mood. Family say she is still inclined to be lazy at times, when she just lies around the house and does nothing. She has several girl friends, but does not go out with boys.

E.B. # - Operated on in May, 1937.

Complains of more menstrual pain since the operation, but seems well-satisfied otherwise. She is at home with her family looking after the house. She says she has had no boy friends since she was at the Hospital. Her main interests are in the church where she sings in the Choir. She attends the occasional movie but spends considerable time at home.

E.B. # - Operated on in August, 1938.

Stopped attending Senior Special Class last June at the age of twenty years. Is now at home with her family and helps with the work in general. She would like to get a job doing housework, but parents have not heard of a suitable one. Has no complaints about the operation.

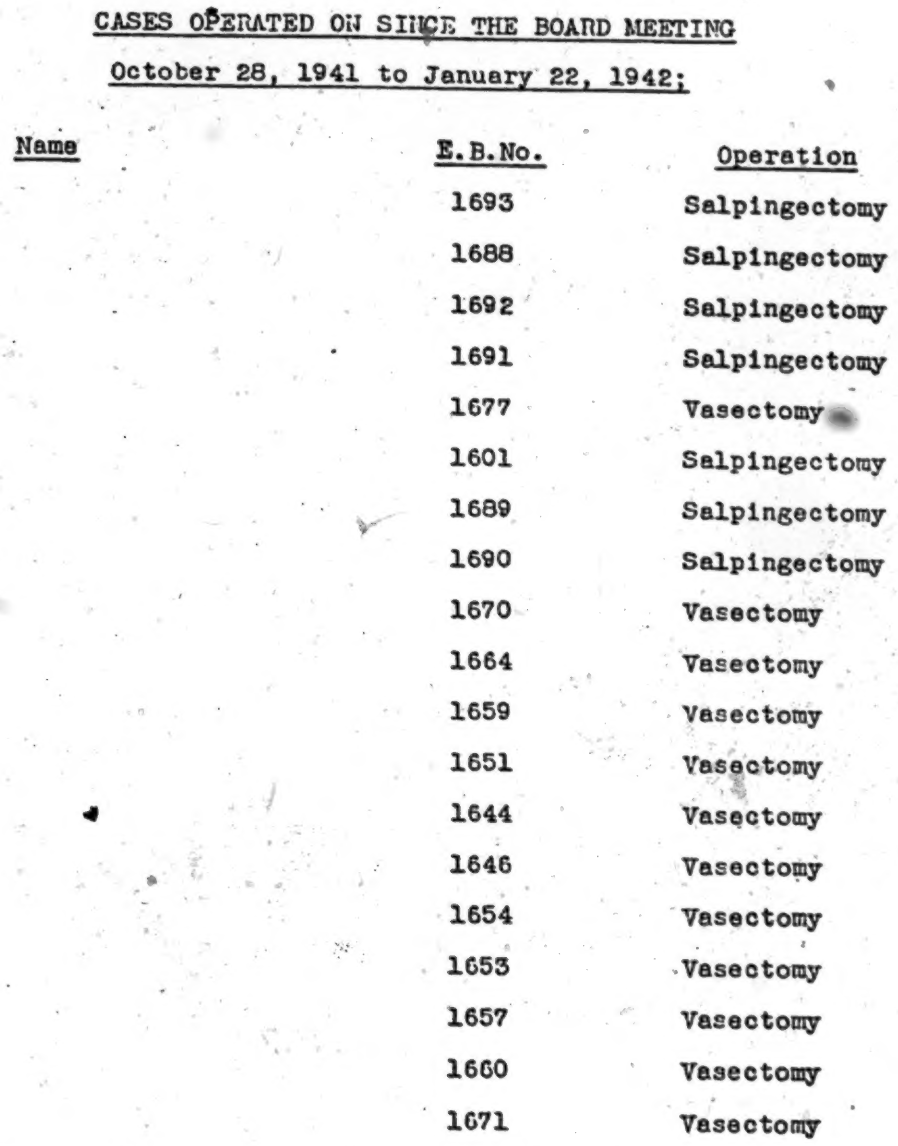
E.B. # - Operated on in June 1941.

Mother seems well satisfied with the operation. was seen at a recent Guidance Clinic and reported to the doctor that he still masturbates about three times a day with the same effects as before the operation. He has gained considerable weight in the past year. He is at home with his family at present.

E.B. # - Operated on in December 1939.

Is going to school this year for the first time and is attend- in the Senior Girls' Special Class. Teacher is attempting to teach her how to read and write. She is now using her partially paralysed arm more than formerly. Is still taking epileptiform attacks at home and in school. Is taking luminal for her spells and insulin for her diabetes. Her sister, with whom she is living, says that she can now do more household tasks, but a series of mental ratings taken over a period of time, indicates that she is deteriorating mentally.

Appendix 7: Sample of "List of Cases Operated On"



CASES OPERATED ON SINCE THE BOARD MEETING

October 28, 1941 to January 22, 1942;

Name	E.B.No.	Operation
	1693	Salpingectomy
	1688	Salpingectomy
	1692	Salpingectomy
	1691	Salpingectomy
	1677	Vasectomy
	1601	Salpingectomy
	1689	Salpingectomy
	1690	Salpingectomy
	1670	Vasectomy
	1664	Vasectomy
	1659	Vasectomy
	1651	Vasectomy
	1644	Vasectomy
	1646	Vasectomy
	1654	Vasectomy
	1653	Vasectomy
	1657	Vasectomy
	1660	Vasectomy
	1671	Vasectomy

Appendix Table 1: Annual Rates of Sterilization by Gender in Alberta 1929-1972 and the United States, 1909-1972.

		Annual rates of sterilization (per 100 000 population)[1]		
Province/ State[2]	Year[s]	Male Rate	Female Rate	Total Rate
1920s				
U.S.	1924-1927	.78	.74	.74
Oregon	1923-1928	8.60	18.09	13.05
Kansas	1917-1928	4.30	2.29	3.32
Virginia	1924-1928	.021	.539	.28
Washington	1921-1928	.02	.18	.095
1930s				
Alberta	1929-1939	6.39	12.18	9.05
U.S.	1932-1939	2.30	1.50	2.05
California	1928-1935	9.30	11.47	10.34
California	1935-1939	---	---	15.08
Oregon	1928-1935	3.72	9.94	6.68
Kansas	1928-1935	6.08	4.75	5.43
Virginia	1928-1935	8.86	13.42	11.13
North Carol.	1929-1939	1.06	4.0	2.50
Wisconsin	1928-1935	.39	3.86	2.08
Washington	1928-1935	.09	.31	.19
1940s				
Alberta	1940-1949	5.13	7.43	6.21
U.S.	1940-1941	1.33	2.03	1.68
U.S	1947	---	---	0.81
Virginia	1942-1944	---	---	8.48
California	1940-1945	---	---	6.22
North Carol.	1940-1947	1.73	6.04	3.90
1950s				
Alberta	1950-1959	5.87	7.03	6.43
U.S.	1950	---	---	1.01
California	1949-1952	---	---	2.00
North Carol.	1948-1955	---	---	6.65
1960s				
Alberta	1960-1969	5.14	8.06	6.56
North Carol.	1963	---	---	4.24
U.S.	1963	---	---	0.26
1970s				
Alberta	1970-1972	2.72	5.19	3.93
North Carol.	1972	---	---	0.10

[1] For Alberta, the number of sterilizations for the decade was divided by the number of years to obtain the average number of sterilizations per year. This number was then divided by the average population for the time period (e.g., for 1929-1939, census data for 1931 and 1941 were averaged). The result was then multiplied by 100 000 to obtain the sterilization rate. For U.S. rates, a single population total was used (e.g., if the era was 1928-35, 1930 Census data were used).

[2] Alberta data from Basic data file. U.S. data from Gosney and Popenoe (1929), Myerson et al. (1936) and Reilly (1991).